No. 11-398

In the Supreme Court of the United States

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

STATE OF FLORIDA, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

BRIEF FOR PETITIONERS
(Minimum Coverage Provision)

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QUESTION PRESENTED

The minimum coverage provision of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, provides that, beginning in 2014, non-exempted federal income taxpayers who fail to maintain a minimum level of health insurance for themselves or their dependents will owe a penalty, calculated in part on the basis of the taxpayer's household income and reported on the taxpayer's federal income tax return, for each month in which coverage is not maintained in the taxable year. 26 U.S.C.A. 5000A.

The question presented is whether the minimum coverage provision is a valid exercise of Congress's powers under Article I of the Constitution.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-273a) is reported at 648 F.3d 1235. The district court's opinion on petitioners' motion to dismiss (Pet. App. 394a-475a) is reported at 716 F. Supp. 2d 1120. The district court's opinion on cross-motions for summary judgment (Pet. App. 274a-368a) is reported at 780 F. Supp. 2d 1256.

JURISDICTION

The judgment of the court of appeals was entered on August 12, 2011. The petition for a writ of certiorari was filed on September 28, 2011, and was granted on November 14, 2011. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Pertinent constitutional and statutory provisions are set forth in the appendix to this brief.

STATEMENT

A. Statutory Background

Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Affordable Care Act or Act),[1] to address a crisis in the national health care market. Spending in that market accounts for 17.6% of the Nation's economy. 42 U.S.C.A. 18091(a)(2)(B). Insurance is the customary means of payment for services in the health care market, but millions of people cannot obtain insurance. Many cannot afford it, and others are denied it or charged dramatically higher premiums as the result of their medical histories.

The uninsured face enormous obstacles in obtaining health care services. See 42 U.S.C. 18091(a)(2)(E) (congressional finding noting "poorer health and shorter lifespan" of the uninsured). The uninsured do, however, consume health care (frequently in hospital emergency rooms or inpatient facilities), but often they cannot pay for it. As a class, the uninsured shift tens of billions of dollars of costs for the uncompensated care they receive to other market participants annually. That cost-shifting drives up insurance premiums, which, in turn, makes insurance unaffordable to even more people. The Act breaks this cycle through a comprehensive framework of economic regulation and incentives that will im-

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[1] Amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

prove the functioning of the national market for health care by regulating the terms on which insurance is offered, controlling costs, and rationalizing the timing and method of payment for health care services.

1. Health insurance is the customary means of payment for services in the health care market

The customary means by which people pay for services in the U.S. health care market is through insurance, either private or governmental. In 2009, payments by private health insurance and government programs accounted for 84% of total spending on health care consumption. Congressional Budget Office (CBO), *CBO's 2011 Long-Term Budget Outlook* 37 (*Budget Outlook*). Out-of-pocket expenditures accounted for only 13% of spending on health care consumption in 2009, including payments made to satisfy deductibles and co-payments as well as payments for uncovered services. *Ibid.* Other private spending, such as philanthropy, accounted for the remainder. *Ibid.*

The largest federal program providing affordable access to health care is Medicare, which insures virtually all Americans aged 65 years or older, as well as several million others with certain disabilities. See 42 U.S.C. 1395 *et seq.*; *Budget Outlook* 37. In 2009, the federal government spent approximately $500 billion on Medicare—22% of total spending on health care consumption in the country. *Id.* at 36-37.

The federal and state governments jointly finance access to health care for low-income persons through Medicaid, 42 U.S.C. 1396 *et seq.*, and the Children's Health Insurance Program (CHIP), 42 U.S.C. 1397aa *et seq*. In 2009, combined spending on those programs was approximately $390 billion—17% of total spending

on health care consumption in the United States. *Budget Outlook* 36-37. Medicaid and CHIP paid for the health care of 37.6 million non-elderly individuals, 14.2% of the non- elderly population. John Holahan, *The 2007-09 Recession and Health Insurance Coverage*, 30 Health Affairs 145, 148 (2011) (Holahan).

Payments by private insurers constituted about 34% of total spending on health care consumption in 2009. *Budget Outlook* 37. The vast majority of persons with private insurance obtain it through employers. For the non-elderly with private health insurance, 93% of health care expenditures in 2009 was attributable to persons with employer-sponsored or other "group coverage"; only 7% percent was attributable to persons who bought policies in the "non-group" market, in which a person can purchase individual or family coverage apart from an employer or other group. Agency for Healthcare Research & Quality, U.S. Dep't of Health & Human Services (HHS), *NHEA-Aligned MEPS: Projected Expenditure Data Files: 2002-2016*, Tbls. 4H and 5H (Aug. 2009). Employer-sponsored plans insured 156.2 million (59%) of the non-elderly in 2009, while non-group policies covered 13.8 million (5%). Holahan 148.

For decades, the federal government has made employer-sponsored insurance more affordable through favorable tax treatment. Employees generally do not include as income and pay taxes on employers' payments of their health insurance premiums, unlike most other forms of employee compensation. 26 U.S.C. 106 (2006). This tax subsidy for employment-based health insurance was $242 billion in 2009. Office of Mgmt. & Budget, *Analytical Perspectives: Budget of the U.S. Government, Fiscal Year 2011*, Tbl. 16:1 (2010). In addition, employ-

ers can deduct such premium payments as business expenses. 26 U.S.C. 162 (2006 & Supp. III 2009).

Congress also has long regulated certain terms of employer-sponsored health coverage. See CBO, *Key Issues in Analyzing Major Health Insurance Proposals* 79-80 (2008) (*Key Issues*) (citing Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, and Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936. For example, federal law generally bars group health plans from excluding individuals based on "health status-related factors" or charging different premiums for similarly situated employees within a group based on such factors. 42 U.S.C. 300gg-1 (2006); 29 U.S.C. 1182 (2006 & Supp. III 2009). Federal law further requires that insurers offering coverage to small employers (generally defined as those with fewer than 51 employees) accept all small employers that apply. 42 U.S.C. 300gg-11(a) (2006).

Before the Affordable Care Act, these federal efforts to facilitate affordable access to health care services left a significant and discrete gap. With limited exceptions, health insurance purchased in the non-group market did not receive favorable federal tax treatment, so the purchasers had to bear the full costs of premiums. *Key Issues* 9. Nor did federal law generally prevent insurers in that market from varying premiums, or denying coverage altogether, based on an individual's medical condition or history.

Without such rules, insurers deny coverage or charge higher rates for individuals with conditions as common as high blood pressure, asthma, ear infections, and even pregnancy. *47 Million and Counting: Why the Health Care Marketplace Is Broken: Hearing Before the*

S. Comm. on Finance, 110th Cong., 2d Sess. 52 (2008) (Senate Hearing) (Prof. Mark A. Hall); Ed Neuschler, *Policy Brief on Tax Credits for the Uninsured and Maternity Care* 3 (2004). A recent survey estimated that 35% of non-elderly adults who tried to purchase health insurance in the non-group market in the previous three years (about 9 million people) were denied coverage, charged a higher rate, or offered restricted coverage because of their medical condition or history. Sara R. Collins et al., *Help on the Horizon, Findings from the Commonwealth Fund Biennial Health Insurance Survey of 2010* xi (2011).

Because participants in the non-group market pay higher premiums and face other discriminatory insurance practices, participation in that market is low. *Key Issues* 46. In 2009, of those non-elderly individuals who did not work for employers offering health insurance or who were not eligible for a government insurance program, only about 20% were covered by a policy purchased in the non-group insurance market. *Ibid*. The remaining 80% were uninsured. *Ibid*. These same factors also may induce people with employer-sponsored insurance to avoid putting their insurance at risk by switching jobs or pursuing entrepreneurial opportunities. *Id.* at 8 & n.12.

Notwithstanding the large number of uninsured at any given time, most of the uninsured are not permanently without health insurance. Instead, they move in and out of coverage. See John L. Czajka & James Mabli, *Analysis of Transition Events in Health Insurance Coverage* 1, 10 (2009) (Czajka). The coverage gaps they experience result for the most part from the high cost of insurance and employment changes—not a belief that coverage is unnecessary. See John A. Graves &

Sharon K. Long, *Why Do People Lack Health Insurance?* 4 (2006) (Graves).

2. The uninsured participate in the health care market and shift substantial risks and costs to other market participants

About 50 million people lacked health insurance in 2009. U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2009*, Tbl. 8, at 23 (2010). The lack of insurance coverage seriously impairs the ability of this class to obtain adequate health care. But it does not foreclose access completely. For decades, state and federal laws—reflecting deeply rooted societal values—have required emergency rooms to stabilize patients who arrive with an emergency condition, and common-law and ethical duties restrict a physician's ability to terminate a patient-physician relationship. See pp. 39-40, *infra*. The uninsured thus participate actively in the market for health care services, even if they cannot pay in full.

As a class, the uninsured consumed $116 billion of health care services in 2008. Families USA, *Hidden Health Tax: Americans Pay a Premium* 2 (2009) (*Hidden Health Tax*). In 2009, more than 55% of Americans under age 65 who were uninsured for more than 12 months had at least one visit to a doctor or an emergency room; about 80% of those who were uninsured for less than 12 months did so. National Ctr. for Health Statistics (NCHS), *DHHS Pub. No. 2011-1232*, *Health, United States, 2010*, Tbl. 79, at 281 (2011); see NCHS, *DHHS Pub. No. 2012-1578*, *Summary Health Statistics for U.S. Children: National Health Interview Survey, 2010*, Tbl. 16, at 43 (2011). The uninsured were hospitalized more than 2.1 million times in 2008. Office of the

Assistant Sec'y for Planning & Evaluation (ASPE), HHS, *ASPE Research Brief: The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills* 5 (May 2011) (ASPE Research Br.). The average bill for a single hospital stay for an uninsured person was $22,200, and nearly 60% of those hospitalizations generated bills greater than $10,000. *Id.* at 5, 8.

Individuals without insurance can rarely cover charges of this magnitude. Even uninsured families with income above 400% of the federal poverty level—*i.e.*, starting at just under $90,000 for families of four—have sufficient assets to pay their full hospital bills for only 37% of their hospitalizations. ASPE Research Br. 6. In 2008, people without insurance did not pay for 63% of their health care costs. *Hidden Health Tax* 2, 6. Third-party sources, including government programs (like Medicaid disproportionate share hospital payments, 42 U.S.C. 1396r-4) and charities, paid for 26% of their care, totaling $30.2 billion. *Hidden Health Tax* 2, 6. Thirty-seven percent of the uninsured's health care costs, totaling $43 billion, was "uncompensated care" —*i.e.*, care received by uninsured patients but not paid for by them or by a third party on their behalf. *Ibid.*; 42 U.S.C.A. 18091(a)(2)(F). Health care providers pass on much of the cost of that care to private insurers, which pass it on to insured participants in the health care market. 42 U.S.C.A. 18091(a)(2)(F). Congress found that this cost-shifting increases the average premium for insured families by more than $1000 per year. *Ibid.*; see *Hidden Health Tax* 2, 6.

3. The Affordable Care Act

The Affordable Care Act establishes a framework of economic regulation and incentives that will reform health insurance markets, expand access to health care services, control costs, and reduce the market-distorting effects of cost-shifting.

First, Congress made health insurance available to millions more low-income individuals by expanding eligibility for Medicaid. Beginning in 2014, Medicaid eligibility will extend to anyone under age 65 with income up to 133% of the federal poverty level. 42 U.S.C.A. 1396a(a)(10)(A)(i)(VIII).[2] Currently, Medicaid beneficiaries are primarily children in low-income families, their parents, low-income pregnant women, and low-income elderly or disabled individuals. *Budget Outlook* 39. The newly eligible persons will consist primarily of low-income non-elderly adults without dependent children. *Id*. at 38.

Second, Congress enacted taxing measures that encourage expansion of employer-sponsored insurance. The Act establishes new tax incentives for eligible small businesses to purchase health insurance for their employees. 26 U.S.C.A. 45R. In addition, the Act's employer responsibility provision imposes a tax liability under specified circumstances on large employers that do not offer adequate coverage to full-time employees. 26 U.S.C.A. 4980H.

Third, Congress provided for creation of health insurance exchanges to enable individuals and small businesses to leverage their collective buying power to ob-

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[2] Except in Alaska and Hawaii, the federal poverty level in 2010 was $10,830 for one person and $22,050 for a family of four. 75 Fed. Reg. 45,629 (Aug. 3, 2010).

tain health insurance at rates competitive with those charged for typical large employer plans. 42 U.S.C.A. 18031-18044.

Fourth, Congress enacted market reforms that will make affordable insurance available to millions who cannot now obtain it. Certain reforms have already taken effect, including provisions that bar insurers from canceling insurance absent fraud or intentional misrepresentation, 42 U.S.C.A. 300gg-12, and from placing lifetime caps on benefits, 42 U.S.C.A. 300gg-11. In addition, the Act establishes medical loss ratios for insurers, *i.e.*, minimum percentages of premium revenues that insurers must spend on clinical services and activities that improve health care quality, as opposed to administrative costs or profits. See 42 U.S.C.A. 300gg-18(b). The Act also requires insurers providing family coverage to continue covering adult children until age 26, 42 U.S.C.A. 300gg-14, which has led to an additional 2.5 million young adults gaining coverage, see ASPE, HHS, *ASPE Issue Brief: 2.5 Million Young Adults Gain Health Insurance Due to the Affordable Care Act* (2011).

Beginning in 2014, the Act will bar insurers from denying coverage to any person because of medical condition or history, 42 U.S.C.A. 300gg-1, 300gg-3, 300gg-4(a) (guaranteed-issue provision), and from charging higher premiums because of a person's medical condition or history, 42 U.S.C.A. 300gg(a)(1), 300gg-4(b) (community-rating provision).

Fifth, Congress enacted new tax credits, cost-sharing reduction payments, and tax penalties as incentives for individuals to maintain a minimum level of health insurance. The Act establishes federal premium tax credits to assist eligible individuals with household income up to 400% of the federal poverty level purchase insurance

through the new exchanges. 26 U.S.C.A. 36B. These premium tax credits, which are advanceable and fully refundable such that individuals with little or no income tax liability can still benefit, are designed to make health insurance affordable by reducing a taxpayer's net cost of insurance. The credits will be available even to families with incomes at (and above) the median level, which, in 2010, was $75,148 for a family of four and $42,863 for an individual.[3] For eligible individuals with income up to 250% of the federal poverty level, the Act also authorizes federal payments to insurers to help cover those individuals' cost-sharing expenses (such as co-payments or deductibles) for insurance obtained through an exchange. 42 U.S.C.A. 18071(c)(2). CBO projected that 83% of people who buy non-group insurance policies through exchanges will receive premium tax credits, *CBO's Analysis of the Major Health Care Legislation Enacted in March 2010*, Tbl. 3, at 18-19 (Mar. 30, 2011) (20 million of 24 million), and that those credits, on average, will cover nearly two-thirds of the premium, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 6 (Nov. 30, 2009).

In addition to those incentives through tax and other subsidies to purchase health insurance, Congress assigned adverse tax consequences to the alternative of attempted self-insuring. Congress provided that, beginning in 2014, non-exempted federal income taxpayers who fail to maintain a minimum level of health insurance coverage for themselves or their dependents will owe a tax penalty for each month in the tax year during which

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[3] See U.S. Census Bureau, *Current Population Survey, Annual Social and Economic Supplement*, Tbl. FINC-01 (Sept. 13, 2011) (Selected Characteristics of Families by Total Money Income).

minimum coverage is not maintained. 26 U.S.C.A. 5000A. The amount of the penalty will be calculated as a percentage of household income for federal income tax purposes, subject to a floor and capped at the price of forgone insurance coverage. 26 U.S.C.A. 5000A(c). It will be reported on the taxpayer's federal income tax return and assessed and collected by the Internal Revenue Service (IRS) under the Internal Revenue Code in the same manner as other assessable penalties. 26 U.S.C.A. 5000A(b)(2) and (g).

Individuals who are not required to file federal income tax returns for a given year are exempt from the penalty. Congress also exempted individuals whose premium payments would exceed eight percent of their household income, individuals who establish that obtaining coverage would be a hardship under standards to be set by the Secretary of HHS, and members of recognized Indian tribes. 26 U.S.C.A. 5000A(e). Individuals who qualify for religious exemptions, are incarcerated, or are undocumented aliens are not subject to the minimum coverage provision. 26 U.S.C.A. 5000A(d).

Various types of insurance coverage are deemed minimum coverage, including government-sponsored programs such as Medicare, Medicaid, CHIP, and programs offered by the Departments of Defense and Veterans Affairs. 26 U.S.C.A. 5000A(f)(1)(A). Minimum coverage also includes eligible employer-sponsored plans and plans offered in the non-group market. 26 U.S.C.A. 5000A(f)(1)(B)-(D); 42 U.S.C.A 18011.

B. Prior Health Care Reform Efforts

The Act in general, and the insurance reforms in particular, culminated a nearly century-long national effort to expand access to health care by making affordable

health insurance more widely available. As early as 1912, Theodore Roosevelt called for a system of social insurance to protect against illness and other hazards. Anne-Emanuelle Birn et al., *Struggles for National Health Reform in the United States*, 93 Am. J. Pub. Health 86, 86 (2003).

President Franklin Roosevelt's task force for social security legislation initially proposed a joint federal-state health insurance program financed at the state level by mandatory employer and employee contributions and supplemented with federal subsidies. See *The Unpublished 1935 Report on Health Insurance & Disability by the Committee on Economic Security* (Mar. 7, 1935). President Roosevelt, however, ultimately decided to focus first on social insurance for retirement and unemployment, leaving health insurance for further study. See Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America* 17-18 (2003) (Gordon).

In 1945, President Truman called for a compulsory national health insurance program. See *Special Message to the Congress Recommending a Comprehensive Health Program*, 1945 Pub. Papers 475 (Nov. 19, 1945). Although President Truman continued to promote that program after his election in 1948, the legislation was not enacted. See Paul Starr, *The Social Transformation of American Medicine* 281-286 (1982).

In 1965, Congress enacted Medicare and Medicaid, which extended health insurance to elderly and low-income individuals, for whom private insurance was generally inaccessible. See Gordon 28. Yet the inaccessibility of health insurance continued to command sustained national attention in the ensuing decades.

In 1971, President Nixon developed a national health care strategy that included a comprehensive national insurance program. The program would have required employers to provide employees and their dependents with health insurance and pay most of the premiums, while subsidizing coverage for families of the unemployed. See Stuart Altman & David Shactman, *Power, Politics, and Universal Health Care: The Inside Story of a Century-Long Battle* 42-43 (2011). A bill partly based on an expanded proposal by President Nixon was introduced in Congress but substituted a new payroll tax for a direct employer mandate and also made employee participation compulsory. See Flint J. Wainess, *The Ways and Means of National Health Care Reform, 1974 and Beyond*, 24 J. Health Pol. Pol'y & L. 305, 318-319 (1999). Ultimately, however, no reform legislation was enacted during the Nixon administration.

In 1993, President Clinton proposed a "Health Security Plan" that would have required all employers to pay premiums on behalf of their employees and also would have required all employees, except those with very low income, to contribute to their premiums. See CBO, *An Analysis of the Administration's Health Proposal*, at xi (1994).

Alternatives to President Clinton's plan emerged, ranging from federal single-payer plans (extending government-provided health insurance to those not eligible for Medicare or Medicaid) to proposals to expand coverage by requiring individuals to obtain insurance, coupled with tax credits to make insurance affordable. See Manish C. Shah & Judith M. Rosenberg, *Health Care Reform in the 103d Congress—A Congressional Analysis*, 33 Harv. J. on Legis. 585, 595-608 (1996). Plans in the latter category were based on recommenda-

tions by the Heritage Foundation and a group of health care economists and lawyers associated with the American Enterprise Institute, both of which supported the mandatory purchase of private insurance so that the sale of insurance and delivery of health care would take advantage of private-sector market efficiencies. See generally CBO, *A Qualitative Analysis of the Heritage Foundation and Pauly Group Proposals to Restructure the Health Insurance System* (1994). A leading congressional alternative to President Clinton's plan, the Health Equity and Access Reform Today Act of 1993, was modeled on those proposals. It would have mandated that "each individual who is a citizen or lawful permanent resident of the United States shall be covered under * * * a qualified health plan, or * * * an equivalent health care program" such as Medicare or Medicaid. S. 1770, 103d Cong., 1st Sess. § 1501 (1993). Neither President Clinton's proposal nor the alternative bill was enacted.

In the absence of federal reform, a number of States attempted their own efforts to broaden access to health care services by ending discriminatory insurance practices. "Kentucky, Maine, New Hampshire, New Jersey, New York, Vermont, and Washington enacted legislation that required insurers to guarantee issue to all consumers in the individual market, but did not have a minimum coverage provision." Pet. App. 230a-231a (Marcus J.) (quoting Am. Ass'n of People with Disabilities C.A. Amicus Br. 5-6).[4] Because those reforms effectively permitted individuals to purchase insurance after illness or injury struck, "[a]ll seven states suffered from sky-rock-

[4] In the decision below, Judge Marcus concurred in part and dissented in part. Pet. App. 189a. This brief will identify his opinion with the parenthetical (Marcus, J.).

eting insurance premium costs, reductions in individuals with coverage, and reductions in insurance products and providers." *Id.* at 231a (same).

By contrast, Massachusetts in 2006 successfully paired insurance market reforms with a provision requiring individuals to pay a tax penalty if they do not "obtain and maintain creditable coverage." Mass. Ann. Laws ch. 111M, § 2 (LexisNexis Supp. 2011). Congress cited the Massachusetts law as a template for key provisions of the Affordable Care Act, including the minimum coverage provision. See 42 U.S.C.A. 18091(a)(2)(D).

C. Proceedings Below

Respondents are two individuals (Mary Brown and Kaj Ahlburg), the National Federation of Independent Business (NFIB), and 26 States. They filed suit in the District Court for the Northern District of Florida, challenging the constitutionality of several provisions of the Act. As relevant here, the district court held that the minimum coverage provision is not a valid exercise of Congress's commerce or taxing powers. Pet. App. 278a n.4, 296a-350a, 401a-424a.

A divided court of appeals affirmed that ruling. Pet. App. 1a-273a. The court held that the minimum coverage provision is not a valid exercise of Congress's commerce power, *id.* at 63a-156a, or taxing power, *id.* at 157a-172a. Judge Marcus dissented, concluding that the minimum coverage provision falls well within Congress's commerce power. *Id.* at 189a-273a.[5]

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[5] The federal government has contested the standing of the State respondents to challenge the minimum coverage provision, see Cert.-Stage Reply Br. 9-11, as well as NFIB's associational standing, see Mem. in Support of D.Ct. Mot'n to Dismiss 27-28. In the court of appeals, the federal government conceded Brown's standing, Fed. Gov't

SUMMARY OF ARGUMENT

The minimum coverage provision is within Congress's powers under Article I of the Constitution.

1. Congress had authority under the Commerce and Necessary and Proper Clauses to enact the minimum coverage provision. The Affordable Care Act expands access to health care services and controls health care costs by reforming the terms on which health insurance is offered and rationalizing the timing and means of payment for health care services. It does so by ending discriminatory insurance practices that have excluded millions of individuals from coverage based on medical history; creating State-based exchanges to further competition and lower prices in the individual and small-group market; using tax credits and penalties to expand the availability of employer-provided coverage and make individual coverage more affordable; and expanding eligibility for Medicaid.

The minimum coverage provision plays a critical role in that comprehensive regulatory scheme by regulating how health care consumption is financed. It creates an incentive for individuals to finance their participation in the health care market by means of insurance, the customary way of paying for health care in this country,

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C.A. Br. 6 n.1, but she has closed the business discussed in the declaration filed in the district court to support her standing. See Letter from Gregory G. Katsas, Jones Day, to Denise J. McNerney, Merits Cases Clerk, Sup. Ct. of the U.S. (Dec. 7, 2011) (Katsas letter) and attached Voluntary Petition, *In re Brown*, No. 5:11-bk-50521 (Bankr. N.D. Fla. filed Sept. 30, 2011); J.A. 140-142. The federal government has supported a motion in this Court to add as parties two NFIB members whose standing allegations are materially identical to those made by Brown before the filing of her bankruptcy petition. See Unopposed Motion for Leave to Add Parties Dana Grimes and David Klemencic (Jan. 4, 2012).

and it works in tandem with the Act's other provisions to expand the availability and affordability of health insurance coverage. In particular, the minimum coverage provision is key to the viability of the Act's guaranteed-issue and community-rating provisions. Those market reforms will end discriminatory practices under which millions of Americans are denied coverage, or charged unaffordable rates, based on medical condition or history. Federal law previously applied similar protections in the employer-sponsored group-insurance market; the guaranteed-issue and community-rating provisions thus serve to fill a gap by requiring insurers who sell policies directly to individuals to operate under similar norms of non-discrimination. As demonstrated by the experience of States that attempted such reforms without a minimum coverage provision, guaranteed-issue and community-rating enacted in isolation create a spiral of higher costs and reduced coverage because individuals can wait to enroll until they are sick. As Congress found, the minimum coverage provision is thus necessary to achieve Congress's concededly valid objective of reforming the interstate market in health insurance.

The minimum coverage provision is within Congress's power to enact not only because it is a necessary component of a broader scheme of interstate economic regulation, see *e.g.*, *Hodel* v. *Indiana*, 452 U.S. 314, 329 n.17 (1981); *United States* v. *Darby*, 312 U.S. 100, 119-120 (1941), but also because, within that scheme, the provision itself regulates economic conduct with a substantial effect on interstate commerce, namely the way in which individuals finance their participation in the health care market, 42 U.S.C.A. 18091(a)(2)(A). Individuals without insurance actively participate in the health care market, but they pay only a fraction of the cost of

the services they consume. As Congress found, the uninsured consumed approximately $116 billion in health care services in 2008, and providers were not compensated for $43 billion of that total. 42 U.S.C.A. 18091(a)(2)(F). Those costs are shifted to other market participants, raising the average family's annual health insurance premiums by more than $1000. *Ibid.* In sum, the uninsured as a class presently externalize the risks and costs of much of their health care; the minimum coverage provision will require that they internalize them (or pay a tax penalty). This is classic economic regulation of economic conduct.

Respondents do not contest Congress's authority to regulate the financing of health care consumption. Instead, they contend that the particular means Congress employed—a minimum insurance coverage provision that applies in advance of health care consumption—was beyond its power. But Congress has wide latitude when deciding how best to achieve its constitutional objectives, and its decision to adopt a minimum coverage provision was eminently reasonable. Insurance is by far the predominant means of paying for health care in this country, and that prevalence reflects the realities of the market. Unlike costs in other markets, many health care costs cannot reasonably be anticipated and budgeted for. The frequency, timing, and magnitude of an individual's overall demand for health care services are largely unknowable. Thus, the uninsured, as a class, pay only 37% of their health care costs out of pocket. Pet. App. 193a (Marcus, J.). Because health insurance is the principal mechanism for meeting these unpredictable and often expensive liabilities, it was reasonable for Congress to invoke that same mechanism to address the problem of uncompensated care.

The court of appeals was of the view that Congress's only choice in enacting a minimum coverage provision was to "require those who consume health care to pay for it with insurance when doing so." Pet. App. 119a. No constitutional principle supports such a limitation on Congress's choice of means for achieving its constitutionally authorized ends. Congress's decision to require insurance in advance, rather than attempting to apply a minimum coverage provision at the point of consumption, was particularly reasonable in light of the economic realities of insurance (which must be obtained before the need to use it arises) and the well-established legal duty of health care providers to provide emergency care regardless of ability to pay (which makes restrictions at the "point of sale" infeasible as well as inhumane). Indeed, the court of appeals' reasoning parallels the now-discarded approach to the commerce power under which the Court attempted to impose semantic and formalistic limitations on its exercise.

2. Congress's taxing power provides an independent ground to uphold the minimum coverage provision. In "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson* v. *Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941) (citation omitted). The practical operation of the minimum coverage provision is as a tax law. The only consequences of a failure to maintain minimum coverage are tax consequences: non-exempted federal income taxpayers will have increased tax liability for those months in which they fail to maintain minimum coverage for themselves or their dependents. That additional tax liability will be calculated on the basis of the taxpayer's household income (subject to a floor and a

cap), reported on the taxpayer's federal income tax return, and collected by the IRS.

The fact that the minimum coverage provision—like longstanding tax provisions such as the exclusion of employer-paid health insurance premiums from employees' taxable income—is intended to encourage health insurance coverage has no bearing on the taxing power inquiry. It is well settled that a tax "does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed." *United States* v. *Sanchez*, 340 U.S. 42, 44 (1950).

Likewise, that Congress used the word "penalty" in the minimum coverage provision, 26 U.S.C.A. 5000A(b), rather than "tax," is immaterial to whether it was a proper exercise of Congress's power over taxation. So too is the fact that Section 5000A includes the predicate for the penalty in a different subsection than those governing the penalty's calculation, assessment, and collection.

ARGUMENT

I. THE MINIMUM COVERAGE PROVISION IS A VALID EXERCISE OF CONGRESS'S COMMERCE POWER

A. Congress Has Broad Power Under The Commerce And Necessary And Proper Clauses To Enact Economic Regulation

1. The Constitution grants Congress the power "[t]o regulate Commerce * * * among the several States." Art. I, § 8, Cl. 3. "[T]he power to regulate commerce is the power to enact 'all appropriate legislation' for 'its protection and advancement'; to adopt measures 'to promote its growth and insure its safety'; 'to foster, protect, control and restrain.' " *NLRB* v. *Jones & Laughlin*

Steel Corp., 301 U.S. 1, 36-37 (1937) (internal citations omitted).

In addition to regulating the "channels of interstate commerce" and "the instrumentalities of interstate commerce, and persons or things in interstate commerce," Congress may "regulate activities that substantially affect interstate commerce." *Gonzales* v. *Raich*, 545 U.S. 1, 16-17 (2005). When Congress acts in this third category, it has the power to "regulate purely local activities that are part of an economic 'class of activities' that have a substantial effect on interstate commerce." *Id.* at 17. And "[w]hen Congress decides that the 'total incidence' of a practice poses a threat to a national market, it may regulate the entire class." *Ibid.* (citation omitted). In reviewing such a determination, the Court's "task * * * is a modest one." *Id.* at 22. The Court "need not determine whether [the regulated] activities, taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." *Ibid.* (citation omitted).

The Necessary and Proper Clause, which authorizes Congress to "make all Laws which shall be necessary and proper for carrying into Execution" its other enumerated powers, Art. I, § 8, Cl. 18, also "grants Congress broad authority to enact federal legislation." *United States* v. *Comstock*, 130 S. Ct. 1949, 1956 (2010); see *Raich*, 545 U.S. at 39 (Scalia, J., concurring in the judgment). While the federal government is one of enumerated powers, "'a government, entrusted with such' powers 'must also be entrusted with ample means for their execution.'" *Comstock*, 130 S. Ct. at 1956 (quoting *McCulloch* v. *Maryland*, 17 U.S. (4 Wheat.) 316, 408 (1819)). "Accordingly, the Necessary and Proper Clause makes clear that the Constitution's grants of specific

federal legislative authority are accompanied by broad power to enact laws that are 'convenient, or useful' or 'conducive, to the authority's 'beneficial exercise.'" *Ibid.* (quoting *McCulloch*, 17 U.S. (4 Wheat.) at 413, 418).

2. Respondents do not contend that the Affordable Care Act's comprehensive market reforms and the ends those reforms advance are beyond Congress's powers under the Commerce Clause and the Necessary and Proper Clause. Respondents do not even dispute that Congress may accomplish those ends through the means of requiring individuals to maintain health insurance in order to receive health care services. Instead, they challenge only one particular feature of the means Congress chose: application of the minimum coverage provision before, rather than at, the "point of consumption" of health care. Yet, as the Court has recognized since the time of Chief Justice Marshall, if "the end be legitimate," *McCulloch*, 17 U.S. (4 Wheat.) at 421, Congress's authority is at its apogee when it determines what means to deploy to achieve that end. See *Comstock*, 130 S. Ct. at 1956; *United States* v. *Darby*, 312 U.S. 100, 121 (1941); *McCulloch*, 17 U.S. (4 Wheat.) at 409-410.

The Act's minimum coverage provision is a particularly well-adapted means of accomplishing Congress's concededly legitimate ends. It is necessary to effectuate Congress's comprehensive reforms of the insurance market, and is itself an economic regulation of the timing and method of financing the purchase of health care services. In both of these respects, the minimum coverage provision regulates economic activity that substantially affects interstate commerce. Its links to interstate commerce are tangible, direct, and strong. See *Comstock*, 130 S. Ct. at 1967 (Kennedy, J., concurring). It is therefore well within the established scope of Congress's

power. See *United States* v. *Lopez*, 514 U.S. 549, 560 (1995).

"Whenever called upon to judge the constitutionality of an Act of Congress—'the gravest and most delicate duty that this Court is called upon to perform'—the Court accords 'great weight to the decisions of Congress.'" *Rostker* v. *Goldberg*, 453 U.S. 57, 64 (1981) (citations omitted). Congress enacted the Affordable Care Act, and chose to include the minimum coverage provision, after years of careful consideration and after a vigorous national debate. That was a policy choice the Constitution entrusts the democratically accountable Branches to make, and the Court should respect it.

B. The Minimum Coverage Provision Is An Integral Part Of A Comprehensive Scheme Of Economic Regulation

The minimum coverage provision is integral to the Affordable Care Act's insurance reforms. Those reforms are part of the Act's broad framework of economic regulation and incentives designed to address the terms on which health insurance is offered, rationalize the timing and method of payment for health care services, expand access to health care, and reduce shifting of risks and costs. That framework builds upon decades of federal involvement in this enormous and highly regulated segment of the national economy. The Act and the preexisting federal statutory structure on which it builds comprehensively address economic conduct having a substantial effect on interstate commerce and are therefore unquestionably within the scope of Congress's commerce power. The minimum coverage provision is necessary to make effective the Act's core reforms of the insurance market, *i.e.*, the guaranteed-issue and community-rating provisions. And the minimum cover-

age provision itself regulates economic conduct with substantial effects on interstate commerce—the manner in which individuals finance and pay for services in the health care market. Even considered in isolation, therefore, the provision is well within the commerce power. See pp. 33-52, *infra*. Because the provision is necessary to make the Act's reforms effective, and is an independently valid economic regulation, it is plainly constitutional.

1. In determining whether a challenged statutory provision is a permissible exercise of the commerce power, the Court considers its role as part of a broader economic regulatory scheme. To sustain provisions that are part of a "complex regulatory program such as established by the [Affordable Care] Act * * * [i]t is enough that the challenged provisions are an integral part of the regulatory program and that the regulatory scheme when considered as a whole" is within the commerce power. *Hodel* v. *Indiana*, 452 U.S. 314, 329 n.17 (1981) (citing *Heart of Atlanta Motel, Inc.* v. *United States*, 379 U.S. 241, 262 (1964), *Katzenbach* v. *McClung*, 379 U.S. 294, 303-304 (1964), *Perez* v. *United States*, 402 U.S. 146, 154-156 (1971), *Wickard* v. *Filburn*, 317 U.S. 111, 127-128 (1942), and *Darby*, 312 U.S. at 123). The Court has therefore "many times held that the power of Congress to regulate interstate commerce extends to the regulation through legislative action of activities intrastate which have a substantial effect on the commerce *or the exercise of the Congressional power over it*." *Darby*, 312 U.S. at 119-120 (emphasis added); see *United States* v. *Wrightwood Dairy Co.*, 315 U.S. 110, 118-120 (1942) (Where Congress has the authority to regulate interstate commerce, "it possesses every power needed to make that regulation effective.").

For example, in *Wickard* the Court upheld the federal regulation of wheat that was neither "sold [n]or intended to be sold" but instead was intended for use only on a single farm. 317 U.S. at 119, 129. The Court held that Congress had power under the Commerce Clause to regulate the interstate market in wheat, and it upheld regulation of the non-commercial home-grown wheat because exercise of that authority was integral to the larger regulatory scheme. *Id.* at 128-129. In *Wickard*, the "potential disruption of Congress's interstate regulation, and not only the effect that personal consumption of wheat had on interstate commerce, justified Congress's regulation of that conduct." *Raich*, 545 U.S. at 37 n.2 (Scalia, J., concurring in the judgment).

Indeed, Congress "may regulate even noneconomic local activity if that regulation is a necessary part of a more general regulation of interstate commerce." *Raich*, 545 U.S. at 37 (Scalia, J., concurring in the judgment) (citing *Lopez*, 514 U.S. at 561)). That "is not a power that threatens to obliterate the line between 'what is truly national and what is truly local,'" *id.* at 38 (quoting *Lopez*, 514 U.S. at 567-568), because Congress can exercise it only when enacting comprehensive regulation that is within its commerce power. See *Seven-Sky* v. *Holder*, 661 F.3d 1, 21 (D.C. Cir. 2011) (Edwards, J., concurring), petition for cert. pending, No. 11-679 (filed Nov. 30, 2011). And where (as here) Congress regulates economic conduct to effectuate a comprehensive scheme, see pp. 33-52, *infra*, it acts well within the full scope of its authority. In the modern era of Commerce Clause jurisprudence beginning with *Jones & Laughlin Steel*, the Court has not once invalidated a provision enacted by Congress as part of a comprehensive scheme of na-

tional economic regulation. Compare *Carter* v. *Carter Coal Co.*, 298 U.S. 238, 297-310 (1936).

2. The minimum coverage provision is an integral part of the Act's comprehensive regulation of the market in health care and health care financing. In particular, it is essential to the Act's reform of discriminatory practices in the individual insurance market. The health care sector occupies a dominant position in the American economy. As Congress found, "[n]ational health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019." 42 U.S.C.A. 18091(a)(2)(B). "Private health insurance spending [was] projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce." *Ibid*. As Congress further found, "[s]ince most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce." *Ibid.*; see *United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533, 539-553 (1944).

The Act supplements the already-pervasive involvement by the federal government in the health care sector, both as a direct payer and as a regulator and subsidizer of private insurance. See pp. 3-5, *supra* (discussing Medicare, Medicaid, CHIP, and tax subsidies for employer-provided insurance). ERISA, for example, "sets out a comprehensive system for the federal regulation of private employee benefit plans, including * * * any 'plan, fund, or program' maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries 'through the purchase of insurance or otherwise.'" *District of Columbia* v. *Greater*

Wash. Bd. of Trade, 506 U.S. 125, 127 (1992) (quoting 29 U.S.C. 1002(1)). "ERISA's pre-emption provision assures that federal regulation of covered plans will be exclusive," *ibid.*, subject to specified exceptions such as that for state regulation of insurance, see 29 U.S.C. 1144(b)(2)(A). In addition, through ERISA and HIPAA, a group health plan may not exclude individuals based on "health status-related factors" or charge different premiums for similarly situated employees based on such factors. See p. 5, *supra*.

Most people have health insurance through coverage that is federally financed, subsidized, or regulated, including Medicare, Medicaid, and employer plans. In 2009, the only health insurance option available to the 45 million people who were not eligible for government programs or employer plans was the "non-group" market. *Key Issues* 46. Of this group, nine million purchased insurance and the remaining 36 million were uninsured. *Ibid.*

Insurers in the non-group market have generally been free to deny coverage or vary premiums based on an applicant's medical condition or history. As a result, "approximately thirty-six percent of applicants in the market for individual health insurance are denied coverage, charged a substantially higher premium, or offered only limited coverage that excludes pre-existing conditions." *Thomas More Law Ctr.* v. *Obama*, 651 F.3d 529, 546 (6th Cir. 2011) (Martin, J.), petition for cert. pending, No. 11-117 (filed July 26, 2011). Along with restrictive underwriting practices, high administrative costs in this market have drastically limited access to coverage.

The guaranteed-issue and community-rating provisions of the Affordable Care Act remove those obstacles to coverage and extend to the non-group market norms

of non-discrimination parallel to those applicable to group health plans. But achieving those results in the individual insurance market required different regulatory tools than those for employer-based plans. In particular, Congress found that without a minimum coverage provision, "many individuals would wait to purchase health insurance until they needed care," taking advantage of the Act's guaranteed-issue and community-rating provisions, 42 U.S.C.A. 18091(a)(2)(I), thereby driving up costs in the non-group market (and, indeed, threatening the viability of that market). Congress therefore determined that the minimum coverage provision "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Ibid.* Noting that "[u]nder [ERISA], the Public Health Service Act, and this Act, the Federal Government has a significant role in regulating health insurance," Congress further found that the minimum coverage provision is "an essential part of this larger regulation of economic activity," and that "the absence of the requirement would undercut Federal regulation of the health insurance market." 42 U.S.C.A. 18091(a)(2)(H) (internal citations omitted).[6]

Ample evidence before Congress supported its conclusion that the minimum coverage provision is indispensable to the viability of the Act's guaranteed-issue and community-rating reforms, which were unquestion-

[6] Congress also found that, "[b]y significantly increasing health insurance coverage," the minimum coverage provision, "together with the other provisions of this Act, will minimize * * * adverse selection[,] broaden the health insurance risk pool to include healthy individuals" who could otherwise exploit the system, and, in turn, "lower health insurance premiums." 42 U.S.C.A. 18091(a)(2)(I).

ably within Congress's commerce power to enact. See *South-Eastern Underwriters Ass'n*, 322 U.S. at 539-553; see also *Comstock*, 130 S. Ct. at 1967 (Kennedy, J., concurring in the judgment) (discussing "a demonstrated link in fact, based on empirical demonstration"). For example, citing New Jersey's experience, Princeton University Professor Uwe Reinhardt explained that "[i]t is well known that community-rating and guaranteed issue coupled with voluntary insurance tends to lead to a death spiral of individual insurance." *Making Health Care Work for American Families: Hearing Before the Subcomm. on Health of the House Comm. on Energy & Commerce,* 111th Cong., 1st Sess. 10 (Mar. 17, 2009). In the wake of such legislation in New York without a minimum coverage provision, "[t]here was a dramatic exodus of indemnity insurers from New York's individual market." Mark A. Hall, *An Evaluation of New York's Reform Law*, 25 J. Health Pol. Pol'y & L. 71, 91-92 (2000); see Pet. App. 230a-231a (Marcus, J.) (discussing similar failures in Kentucky, Maine, New Hampshire, Vermont, and Washington).

In contrast, Congress found that Massachusetts avoided these perils by enacting a minimum coverage provision as part of broader insurance reforms. That Massachusetts law "has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased." 42 U.S.C.A. 18091(a)(2)(D). There is therefore substantial support for Congress's conclusion that the minimum coverage provision "is 'necessary' to the end of regulating insurers' underwriting practices without running insurers out of business." Pet. App. 231a (Marcus, J.).

3. More broadly, the minimum coverage provision and the insurance reforms for the non-group market will contribute to the success of other measures in the Affordable Care Act that further the Act's goals in other ways. For example, the Act provides for the creation of exchanges, either by a State (or a group of States) or the federal government, to enable individuals and small businesses to leverage their collective buying power to obtain insurance at rates competitive with those of typical large employer plans. 42 U.S.C.A. 18031-18044. These exchanges will function "as an organized and transparent marketplace for the purchase of health insurance where individuals and employers * * * can shop and compare health insurance options." H.R. Rep. No. 443, 111th Cong., 2d Sess. Pt. 2, at 976 (2010) (2010 House Report) (quotation marks and footnote omitted). Insurers offering policies in the exchanges must comply with the Act's insurance market reforms; Congress thus contemplated that all insurers in the exchanges would "compete [not] based on risk selection" but instead "based on quality and efficiency." *Id.* at 975-976; cf. *Darby*, 312 U.S. at 115 (Congress can use its commerce power to restrict competition on grounds "injurious to * * * commerce"). The exchanges would be less effective in promoting competition and lowering costs without those reforms.

To take another example, the Act will provide substantial tax credits for insurance purchased by eligible taxpayers in the insurance exchanges, 26 U.S.C.A. 36B, and federal cost-sharing reduction payments to defray eligible individuals' co-payments and deductibles in plans purchased through an exchange, 42 U.S.C.A. 18071. Those tax credits and payments will subsidize many individuals who maintain insurance coverage,

while the minimum coverage provision operates in parallel by requiring payments to the government by those non-exempted individuals who do not maintain coverage. The minimum coverage provision similarly complements provisions of the Act (as well as pre-existing measures) that encourage employers to offer health insurance to their employees. See pp. 4-5, 9, *supra*. It provides an extra incentive for employees to seek and accept, and employers to offer, coverage through the workplace. See Matthew Buettgens et al., *Why the Individual Mandate Matters: Timely Analysis of Immediate Health Policy Issues* 5 (2010) (Act without minimum coverage provision would result in nearly seven million fewer individuals covered by employer-sponsored insurance than Act with it).

In sum, the Act closes a gap that has undermined Congress's longstanding system of regulation and financial incentives in the health care market and that has impeded the ability of millions of Americans to obtain services in that market. The minimum coverage provision is key to the insurance reforms that were designed to fill that gap. The provision is therefore within Congress's commerce power.[7]

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[7] Instead of deferring to Congress's judgments, the court of appeals made its own *de novo* assessment and concluded that, in its view, the minimum coverage provision will not adequately accomplish Congress's objectives because of its exemptions and enforcement mechanisms. Pet. App. 151a-152a. That analysis was "startlingly like strict scrutiny review" and has no place in review of an Act of Congress under the commerce power. *Id.* at 218a (Marcus, J.). It is for Congress, not the courts, to decide how to balance its legislative goals with other concerns. See *Preseault* v. *ICC*, 494 U.S. 1, 19 (1990). In the CBO's expert judgment, by 2019, the Act will reduce the number of non-elderly individuals without insurance by approximately 33 million, resulting in 95% of Americans having coverage (up from 83% today); the CBO has

C. The Minimum Coverage Provision Itself Regulates Economic Conduct With A Substantial Effect On Interstate Commerce

The minimum coverage provision is within Congress's power to enact not only because it is a necessary component of a broader scheme of interstate economic regulation, but also because, within that scheme, it regulates economic conduct with a substantial effect on interstate commerce: the way in which individuals finance their participation in the health care market.

1. The minimum coverage provision reasonably regulates the financing of participation in the health care market and is a reasonable means to prevent the shifting of costs and risks to other market participants

a. As Congress expressly found, the minimum coverage provision "regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased." 42 U.S.C.A. 18091(a)(2)(A). "In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers." *Ibid.* Congress had far more than a rational basis for concluding that the

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attributed about half of that projected decrease in the number of nonelderly uninsured—16 million people—to the direct and indirect effects of the minimum coverage provision. *CBO's March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act* 1 (Mar. 18, 2011); CBO, *Effects of Eliminating the Individual Mandate to Obtain Health Insurance* 2 (June 16, 2010).

practices of "forego[ing] health insurance" and "attempt[ing] to self-insure" has a substantial and deleterious effect on interstate commerce. Congress therefore had power under the Commerce Clause to regulate those practices.

As a class, the uninsured actively participate in the health care market, but they pay only a fraction of the cost of the services they consume. See Pet. App. 193a-194a, 211a-213a (Marcus, J.); pp. 7-8, *supra*. Congress found that the cost of tens of billions of dollars in uncompensated care provided to the uninsured is passed on to insured consumers, raising average annual family premiums by more than $1000. 42 U.S.C.A. 18091(a)(2)(F).

The minimum coverage provision addresses those defects in the health care market. It creates a financial incentive (by means of a tax penalty) for uninsured participants in the health care market to internalize their own risks and costs, rather than externalizing them to others. This constitutes classic economic regulation under the commerce power. As Judge Sutton recognized, "[n]o one must pile 'inference upon inference,' *Lopez*, 514 U.S. at 567, to recognize that the national regulation of a $2.5 trillion industry, much of which is financed through 'health insurance . . . sold by national or regional insurance companies,' 42 U.S.C.A. § 18091(a)(2)(B), is economic in nature." *Thomas More*, 651 F.3d at 558 (Sutton, J.).[8] "Where," as is clearly the case here, such "economic activity substantially affects interstate commerce, legislation regulating that activity will be sustained." *United States* v. *Morrison*, 529 U.S.

[8] Judge Sutton's opinion was partly for the court and was partly a concurrence in the judgment. See *Thomas More*, 651 F.3d at 533. When citing to the portion of his opinion that was a concurrence in the judgment, this brief will use the parenthetical (Sutton, J.).

598, 610 (2000) (quoting *Lopez*, 514 U.S. at 560); *Lopez*, 514 U.S. at 574 (Kennedy, J., concurring) ("Congress can regulate in the commercial sphere on the assumption that we have a single market and a unified purpose to build a stable national economy.").

b. A requirement that individuals maintain a minimum level of insurance to finance their own health care needs and those of their dependents (or else pay a tax penalty) is manifestly an "appropriate means" (*McCulloch*, (4 Wheat.) 17 U.S. at 410), of addressing the substantial economic problems created by uncompensated care.

Insurance is by far the predominant method of paying for health care in this country. See p. 3, *supra*. That predominance reflects the realities of the health care market. That market, unlike others with essentially universal participation (like the markets for food and housing), involves needs that cannot reasonably be anticipated and budgeted for. For example, when a heart attack or appendicitis strikes, a person cannot postpone a hospital visit in order to save enough money for it, as can be done for purchasing a home or car. Nor can a family be assured that a budgeted amount for anticipated doctor visits will be adequate, as it can for food purchases.

The frequency, timing, and magnitude of an individual's demand for health care services are largely unknowable. J.P. Ruger, *The Moral Foundations of Health Insurance*, 100 QJM 53, 54-55 (2007); see also Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 941, 948-949 (1963). Indeed, "[m]ost medical expenses for people under 65" result "from the 'bolt-from-the-blue' event of an accident, a stroke, or a complication of pregnancy

that we know will happen on average but whose victim we cannot (and they cannot) predict well in advance." *Expanding Consumer Choice and Addressing "Adverse Selection" Concerns in Health Insurance: Hearing Before the Joint Economic Comm.*, 108th Cong., 2d Sess. 32 (2004) (Prof. Mark V. Pauly). As Judge Sutton observed, an "individual can count on incurring some healthcare costs each year (*e.g.*, an annual check-up, insulin for a diabetic) but cannot predict others (*e.g.*, a cancer diagnosis, a serious accident)." *Thomas More*, 651 F.3d at 557.

In addition, costs can mount rapidly for even common medical procedures. For example, approximately one in three babies in the U.S. is born by cesarean delivery, costing, on average, more than $13,000. See Joyce A. Martin et al., *Births: Final Data for 2009*, Nat'l Vital Statistics Reports, Nov. 2011, at 3; International Fed'n of Health Plans, *2010 Comparative Price Report: Medical and Hospital Fees by Country* 12. The average cost of an appendectomy is also $13,000; of an angioplasty, $29,000; of bypass surgery, nearly $60,000. *Id.* at 14, 16, 17.

For these reasons, "most Americans manage the risk of not having the assets to pay for health care by purchasing medical insurance." *Thomas More*, 651 F.3d at 557 (Sutton, J.); see Pet. App. 246a (Marcus, J.). These same considerations amply demonstrate that it was reasonable for Congress to address the problem of uncompensated care by imposing a tax penalty on individuals who do not maintain a minimum level of insurance to meet such health care needs. States have mandated insurance when (as here) an individual's lack of insurance shifts risks to others. See 1 Steven Plitt et al., *Couch on Insurance 3d* § 1:50 (rev. ed. 2009) (discussing

mandatory automobile insurance laws). Congress therefore acted well within its constitutional authority by adopting a means of regulation parallel to insurance measures enacted by the States to address comparable risk-shifting, for "[t]he authority of the federal government over interstate commerce does not differ in extent or character from that retained by the states over intrastate commerce," *Darby*, 312 U.S. at 116 (citation omitted). See also 49 U.S.C. 13906 (mandatory liability insurance for interstate motor carriers).

2. The court of appeals misapprehended the nature of the minimum coverage provision, the mechanics of health insurance, and this Court's precedents

a. The court of appeals did not take issue with the premises that underlie the minimum coverage provision, or with the legitimacy of the ends Congress sought to achieve, or even with the accomplishment of those ends through the means of a minimum coverage provision. To the contrary, the panel majority acknowledged that requiring individuals to maintain health insurance is a proper means of regulating payment in the market for health care services and that Congress could constitutionally "require those who consume health care to pay for it with insurance when doing so." Pet. App. 118a-119a. Respondents have likewise acknowledged that "Congress may constitutionally require the uninsured to obtain health care insurance on the hospital doorstep, or that Congress may otherwise impose a penalty on those who attempt to consume health care services without insurance." *Id.* at 207a (Marcus, J.); see States C.A. Br. 31-32.

The panel majority objected, however, to the particular policy choice Congress made in deciding how best to

accomplish the Act's concededly legitimate objectives. The minimum coverage provision in the Affordable Care Act exceeds the commerce power, the majority declared, because it "does *not* regulate behavior at the point of consumption" of health care. Pet. App. 118a. The majority concluded that Congress may not require those who fail to maintain minimum coverage to pay a tax penalty, and that, instead, Congress's only permissible option is to impose an insurance requirement at the point at which health care services are provided. See *id.* at 118a-119a.

No constitutional principle authorized the court of appeals to set aside Congress's considered judgment regarding the appropriate means for carrying out the Act's objectives, including the precise framing of a minimum coverage provision. The Constitution "'address-e[s]' the 'choice of means' 'primarily . . . to the judgment of Congress.'" *Comstock*, 130 S. Ct. at 1957 (brackets in original) (citation omitted). As Judge Sutton correctly recognized, "[r]equiring insurance today and requiring it at a future point of sale amount to policy differences in degree, not kind, and not the sort of policy differences removed from the political branches by the word 'proper' or for that matter 'necessary' or 'regulate' or 'commerce.'" *Thomas More*, 651 F.3d at 563; see *Seven-Sky*, 661 F.3d at 18; Pet. App. 216a (Marcus, J.). Indeed, the objective of a "point of consumption" regulation presumably would not be to deny health care to those without insurance; rather, it would be to create an incentive, albeit a draconian one, for the uninsured to obtain insurance before they need health care—precisely what the minimum coverage provision seeks to accomplish, but in a more reasonable and humane manner.

The panel majority's focus on the point of health care "consumption" conflicts with the economic rationale for insurance, which necessarily must be obtained before the need to use the coverage arises. A "health insurance market could never survive or even form if people could buy their insurance on the way to the hospital." Senate Hearing 52 (Prof. Mark A. Hall). It therefore was surely reasonable for Congress to conclude that its ends were most appropriately served by applying the minimum coverage provision *before* the point of consumption of health care services.

The panel majority's reasoning also disregards realities of the health care services market, and deeply ingrained societal norms, that would render infeasible an insurance requirement imposed at "the point of consumption." State court rulings have long imposed "a common law duty on doctors and hospitals to provide necessary emergency care," notwithstanding a patient's inability to pay. H.R. Rep. No. 241, 99th Cong., 1st Sess. Pt. 3, at 5 (1985) (1985 House Report); see, *e.g.*, *Ricks* v. *Budge*, 64 P.2d 208, 210-213 (Utah 1937) (doctors); *Walling* v. *Allstate Ins. Co.*, 455 N.W.2d 736, 738 (Mich. Ct. App. 1990) (hospitals). Many States, including a number of the respondent States, have statutory requirements to the same effect. See 1985 House Report Pt. 3, at 5;[9] see also *Code of Medical Ethics of the American Medical Association* (2010) (Opinion 9.065: Caring for the Poor) ("Each physician has an obligation to share in providing care to the indigent.").

[9] See also, *e.g.*, Fla. Stat. Ann. § 395.1041(3)(k)(1) (West 2011); Idaho Code Ann. § 39-1391b (2011); La. Rev. Stat. Ann. § 40:2113.4(A) (2008); S.C. Code Ann. § 44-7-260(E) (2002); Tex. Health & Safety Code Ann. § 311.022(a) and (b) (Vernon 2010); Utah Code Ann. § 26-8a-501(1) (2007); Wash. Rev. Code Ann. § 70.170.060(2) (West 2011).

Finding these measures inadequate to prevent "hospital emergency rooms [from] refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance," 1985 House Report Pt. 1, at 27, Congress in 1986 augmented the patchwork of state laws through enactment of the Emergency Medical Treatment and Labor Act, 42 U.S.C. 1395dd. That statute requires all hospitals participating in Medicare and offering emergency services to stabilize any patient who arrives with an emergency condition, without regard to evidence of ability to pay. See *Roberts* v. *Galen of Va., Inc.*, 525 U.S. 249 (1999).

It was clearly proper for Congress to take into account these legal norms, and the societal judgments they reflect, in determining that denying health care to persons without insurance, or otherwise attempting to penalize them at a time of medical need, was an inappropriate means of addressing uncompensated care. Cf. *Comstock*, 130 S. Ct. at 1961 (noting the "common law" duty not to release dangerous persons in one's custody, in finding it "necessary and proper" for Congress to confine a federal prisoner whose mental illness threatens others).

b. Respondents contend that Congress was without authority to enact the minimum coverage provision to address the distorting effects of risk-shifting and cost-shifting in the market for health care services because the provision is a regulation of health *insurance*, which, they insist, is a different market. See, *e.g.*, NFIB Cert.-Stage Br. 5-8. The uninsured, respondents assert, are "strangers to commerce in health insurance," and the minimum coverage provision is unconstitutional because it "is not tied to those who do not pay for a portion of

their health care." *Id.* at 5, 7 (internal citation omitted). These contentions rest on several fundamental errors.

First, this Court has repeatedly rejected efforts, like respondents', to put particular conduct beyond Congress's commerce power by artificially isolating it from the overall commerce of which it is a part. See *Mandeville Island Farms, Inc.* v. *American Crystal Sugar Co.*, 334 U.S. 219, 227-229 (1948); *United States* v. *Rock Royal Co-operative, Inc.*, 307 U.S. 533, 568 (1939) (rejecting argument that Congress could not regulate terms of "a local transaction" that was alleged to be "fully completed before any interstate commerce begins"); *Stafford* v. *Wallace*, 258 U.S. 495, 516 (1922) ("Such transactions can not be separated from the movement to which they contribute and necessarily take on its character."). Instead, the Court defers to Congress's judgment about how to define the market it is regulating. See *Wickard*, 317 U.S. at 118-119 (noting that Congress had adopted "a definition of [the wheat] 'market'" that went beyond "its conventional meaning").

Congress properly viewed the minimum coverage provision as a regulation of the financing of health care, *i.e.*, of "activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased." 42 U.S.C.A. 18091(a)(2)(A). No one purchases health insurance for its own sake; it exists only as a means of financing participation in the health care market. See Wendy K. Mariner, *Health Reform: What's Insurance Got to Do With It?*, 36 Am. J.L. & Med. 436, 450 (2010). Congress understood the economic reality that health insurance and health care financing are inherently integrated, and it was permitted to regulate on that basis. Cf. *South-Eastern Underwrit-*

ers Ass'n, 322 U.S. at 540 n.14. & 547 (contract for purchase of insurance is "essentially different from ordinary commercial transactions"; it is necessary to "examine the entire transaction, of which that contract is but a part, in order to determine whether there may be a chain of events which becomes interstate commerce") (citation omitted).

Second, Congress was not required to stay its hand until the point uncompensated care is consumed, or somehow attempt to identify and regulate only "those [uninsured persons] who do not pay for a portion of their health care." NFIB Cert.-Stage Br. 7. Congress may instead regulate the uninsured as a class. See *Seven-Sky*, 661 F.3d at 20. In *Consolidated Edison Co.* v. *NLRB*, 305 U.S. 197 (1938), an employer that had not itself experienced labor strife argued that it could not be subjected to the jurisdiction of the National Labor Relations Board on the theory that labor strife generally affects interstate commerce. *Id.* at 204. The Court rejected that contention, explaining:

> If industrial strife due to unfair labor practices actually brought about [a disruption to interstate commerce], we suppose that no one would question the authority of the Federal Government to intervene * * * . But it cannot be maintained that the exertion of federal power must await the disruption of that commerce. Congress was entitled to provide reasonable preventive measures and that was the object of the National Labor Relations Act.

Id. at 221-222; see *Maryland* v. *Wirtz*, 392 U.S. 183, 192 (1968); *McClung*, 379 U.S. at 301 ("With this situation spreading as the record shows, Congress was not required to await the total dislocation of commerce.").

The Court applied that preventive principle in *Raich*. Like respondents here, Raich claimed that Congress could not regulate her cultivation of marijuana for personal medical use because she was "entirely separated from the market." 545 U.S. at 30 (citation omitted). The Court rejected that artificial limit on Congress's commerce power, see *id.* at 25-33, because "marijuana that is grown at home and possessed for personal use is never more than an instant from the interstate market," *id.* at 40 (Scalia, J., concurring in the judgment). See *Thomas More*, 651 F.3d at 562 (Sutton, J.) ("Angel Raich * * * never entered *any* markets, whether interstate or intrastate, yet Congress regulated [her] nonetheless.").

The same principle applies here. Because of human susceptibility to disease and accident, we are all potentially never more than an instant from the "point of consumption" of health care (Pet. App. 118a), yet it is impossible to predict which of us will need it during any period of time. See *id.* at 210a (Marcus, J.); see also *Jones & Laughlin Steel Corp.*, 301 U.S. at 43 ("Congress [is] entitled to foresee and to exercise its protective power to forestall.").

Third, there is no practical way to limit an insurance requirement to those "who do not pay for a portion of their health care" (NFIB Cert.-Stage Br. 7). Health insurance, by definition, must be purchased before filing a claim. Individuals who think they can go without it will often turn out to be wrong. At the point health care is consumed, it is too late to avoid the market disruption caused by the shifting of risks and costs to others.

Respondents nonetheless attempt to subdivide the uninsured into cost-shifters (who they say can be regulated) and non-cost-shifters (who they say cannot be),

contending that "many healthy individuals make a rational choice to self-insure and are fully capable of paying for the care they receive," States C.A. Br. 30, and that uninsured individuals are able to properly consider their "actuarial risk in self-financing [their] healthcare," NFIB C.A. Br. 23. In reality, the number of those who go without insurance based on what they think is a "rational" choice is minuscule. See Graves 4 (less than three percent of uninsured non-elderly individuals say they have "no need for insurance"; most want coverage but report they cannot obtain it because of high cost or their job situation).

The circumstances of this case well illustrate the flaws in respondents' premises. At the outset of this litigation, respondent Mary Brown thought she had made a rational choice to forgo insurance: she said she did "not believe that the cost of health insurance coverage [was] a wise or acceptable use of [her] financial resources," J.A. 141, apparently believing that she could pay her medical bills out of pocket. That belief proved incorrect. Ms. Brown and her husband recently filed a petition for bankruptcy, and they list among their liabilities thousands of dollars in unpaid medical bills, including bills from out-of-state providers. See Katsas letter, n.5, *supra*, and attached Voluntary Petition, Sch. F. Those liabilities are uncompensated care that will ultimately be paid for by other market participants. As Congress found, Brown's experience is hardly atypical. 42 U.S.C.A. 18091(a)(2)(G) ("62 percent of all personal bankruptcies are caused in part by medical expenses.").

3. The minimum coverage provision is fully consistent with **Lopez** *and* **Morrison** *and the allocation of authority between the federal and state governments*

a. This Court's decisions in *Lopez* and *Morrison* confirm that respondents' challenges to the minimum coverage provision lack merit. In *Lopez*, the Court considered a stand-alone federal criminal statute, "not an essential part of a larger regulation of economic activity," that simply prohibited possession of a firearm near a school. 514 U.S. at 551, 561. The Court explained that "[t]he possession of a gun in a local school zone is in no sense an economic activity that might, through repetition elsewhere, substantially affect any sort of interstate commerce." *Id.* at 567. The government instead sought to justify the *Lopez* statute's connection to commerce primarily by "the threat that firearm possession in and near schools poses to the educational process and the potential economic consequences flowing from that threat." *Id.* at 565. That chain of causation was too attenuated. "To uphold the Government's contentions," the Court would have had "to pile inference upon inference in a manner that would bid fair to convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States." *Id.* at 567.

Likewise, in *Morrison*, the Court concluded that a statute "provid[ing] a federal civil remedy for the victims of gender-motivated violence" was beyond Congress's commerce power. 529 U.S. at 601-602, 613-619. Like the statute at issue in *Lopez*, the civil-remedy provision was not part of a larger scheme of economic regulation, and the Court emphasized that "[g]ender-motivated crimes of violence are not, in any sense of the phrase, economic activity." *Id.* at 613. Accordingly,

defense of the statute rested on the same "method of reasoning" based on attenuated inferences that the Court in *Lopez* had "rejected as unworkable." *Id.* at 615.

The court of appeals' conclusion that the minimum coverage provision runs afoul of the limitations articulated in *Lopez* and *Morrison* (*e.g.*, Pet. App. 133a) thus is incorrect for at least two reasons. First, in both *Lopez* and *Morrison*, "[t]he Court emphasized the noneconomic nature of the regulated conduct" in finding it outside Congress's commerce power. *Sabri* v. *United States*, 541 U.S. 600, 607 (2004); see *Morrison*, 529 U.S. at 610 ("[T]he noneconomic, criminal nature of the conduct at issue [in *Lopez*] was central to our decision in that case."); *Raich*, 545 U.S. at 23, 25.

By contrast, "[h]ealth care and the means of paying for it are 'quintessentially economic' in a way that possessing guns near schools and domestic violence are not." *Thomas More*, 651 F.3d at 557-558 (Sutton, J.) (internal citations omitted); accord *Seven-Sky*, 661 F.3d at 16-17. As in *Raich*, "[b]ecause the [minimum coverage provision] is a statute that directly regulates economic, commercial activity, [the] opinion in *Morrison* casts no doubt on its constitutionality." 545 U.S. at 26.

Second, "[n]either [*Lopez* nor *Morrison*] involved the power of Congress to exert control over intrastate activities in connection with a more comprehensive scheme of regulation." *Raich*, 545 U.S. at 39 (Scalia, J., concurring in the judgment). "The statutory scheme that the Government is defending in this litigation is at the opposite end of the regulatory spectrum." *Id.* at 24; see pp. 27-32, *supra*.

Unlike the statutory provisions in *Lopez* and *Morrison*, the minimum coverage provision is justified on the

basis of a constitutional analysis that poses no risk of "convert[ing] congressional authority under the Commerce Clause to a general police power of the sort retained by the States." *Lopez*, 514 U.S. at 567. Respondents "have not argued that health care and health insurance are uniquely state concerns, and decades of established federal legislation in these areas suggest the contrary." *Seven-Sky*, 661 F.3d at 19. Indeed, respondents do not contest that Congress has the authority to enact the Act's comprehensive regulatory scheme; nor do they question the undeniably pervasive federal role in providing and regulating the methods of health care financing. See pp. 3-5, *supra*. They have also conceded that Congress could constitutionally achieve the end that the minimum coverage provision seeks to achieve through the (more coercive) means of prohibiting individuals without insurance from obtaining health care. Given those concessions, respondents cannot plausibly contend that the minimum coverage provision "upsets the federal balance to a degree that renders it an unconstitutional assertion of the commerce power," *Lopez*, 514 U.S. at 580 (Kennedy, J., concurring), or that it trenches upon areas such as family law, general criminal law, or education, "where States historically have been sovereign," *id.* at 564; see *Seven-Sky*, 661 F.3d at 18-19; *Thomas More*, 651 F.3d at 557 (Sutton, J.) (minimum coverage provision "steers clear of the central defect in the laws at issue in *Lopez* and *Morrison*").

b. Respondents, along with other parties challenging the minimum coverage provision, have contended that it regulates "inactivity" and for that reason is categorically beyond Congress's commerce authority. *E.g.*, States C.A. Br. 20-22. That effort to fashion an unprece-

dented limitation on the commerce power should be rejected.

i. There is no textual support in the Commerce Clause for respondents' "inactivity" limitation. See *Thomas More*, 651 F.3d at 560 (Sutton, J.); *Seven-Sky*, 661 F.3d at 16.

> At the time the Constitution was fashioned, to "regulate" meant, as it does now, "[t]o adjust by rule or method," as well as "[t]o *direct*." To "direct," in turn, included "[t]o prescribe certain measure[s]; to mark out a certain course," and "[t]o order; to command." In other words, to "regulate" can mean to require action.

Seven-Sky, 661 F.3d at 16 (quoting 2 Samuel Johnson, *Dictionary of the English Language* 514, 1619 (4th ed. 1773) (footnotes omitted)); see *Thomas More*, 651 F.3d at 561 (Sutton, J.) ("The power to regulate includes the power to prescribe and proscribe. Legislative prescriptions set forth rules of conduct, some of which require action.") (citations omitted). "Nor was the term 'commerce'" at the time of the founding "limited to only *existing* commerce." *Seven-Sky*, 661 F.3d at 16.

Apart from its lack of a textual foundation, respondents' effort to carve out an abstract category of "inactivity" from Congress's commerce power rests on a mode of analysis this Court long ago rejected. See *Seven-Sky*, 661 F.3d at 17-18. The Court once employed such categories by, for example, attempting to classify conduct as "'production,' 'manufacturing,' [or] 'mining'" and on that basis place that conduct beyond Congress's regulatory power. *Lopez*, 514 U.S. at 554; see also *id.* at 555 (discussing the Court's similar attempt to draw a

"distinction between 'direct' and 'indirect' effects on interstate commerce").

In the "new era of federal regulation under the commerce power," *Lopez*, 514 U.S. at 554, however, the Court has recognized that it is not appropriate to "draw content-based or subject-matter distinctions, thus defining by semantic or formalistic categories those activities that [are] commerce and those that [are] not." *Id.* at 569 (Kennedy, J., concurring). Instead of attempting to apply "mathematical or rigid formulas," the Court "recogni[zes] * * * the importance of a practical conception of the commerce power." *Id.* at 572-573 (Kennedy, J., concurring); see *Wickard*, 317 U.S. at 120 ("[Q]uestions of the power of Congress are not to be decided by reference to any formula which would give controlling force to nomenclature.").

Under the Court's practical approach, it "ha[s] applied the well-settled principle that it is the effect upon interstate or foreign commerce, not the source of the injury, which is the criterion." *Consolidated Edison Co.*, 305 U.S. at 222; see also, *e.g.*, *Jones & Laughlin Steel Corp.*, 301 U.S. at 32 (same). Here, for the reasons explained above, the practice of going without health insurance and seeking to pay for health care in other ways has a massive effect on interstate commerce. The attempt to immunize that conduct from regulation on the theory that it precedes entry into commerce would be analogous to earlier failed attempts to seal off conduct such as "manufacturing" from Congress's commerce power. See *Lopez*, 514 U.S. at 570 (Kennedy, J., concurring). The effort to impose a new "semantic or formalistic" limitation on Congress's commerce power (*id.* at 569) would fail in practice in any event, as did the last such attempts in the 1930s, because the analysis would

turn entirely on the easily malleable level of generality at which a regulation is characterized. See *Thomas More*, 651 F.3d at 560-561 (Sutton, J.) (providing examples); *Seven-Sky*, 661 F.3d at 17 (same).

ii. In any event, respondents are simply incorrect in describing the minimum coverage provision as a regulation of inactivity.

First, the uninsured as a class are active in the market for health care, which they regularly seek and obtain. The minimum coverage provision merely regulates how individuals finance and pay for that active participation—requiring that they do so through insurance, rather than through attempted self-insurance with the back-stop of shifting costs to others. See *Thomas More*, 651 F.3d at 557, 561 (Sutton, J.) ("No one is inactive when deciding how to pay for health care, as self-insurance and private insurance are two forms of action for addressing the same risk.").

In *Wickard*, this Court noted that the statute under review "restrict[ed] the amount which may be produced for market and the extent as well to which one may *forestall resort to the market* by producing to meet his own needs." 317 U.S. at 127 (emphasis added). Congress could regulate home-grown wheat because "it supplie[d] a need of the man who grew it which would otherwise be reflected by purchases in the open market." *Id.* at 128. Here, the constitutional foundation for Congress's action is considerably stronger. The minimum coverage provision regulates the way in which the uninsured finance what they will consume in the market for health care services (in which they participate), requiring that they "resort to the market" for insurance rather than attempt to "meet [their] own needs" through attempted self-insurance. *Id.* at 127.

Second, respondents' argument reflects a fundamental misunderstanding of the economics of insurance. Whether or not an individual receives health care services in any specific time period, he or she is always at risk of needing such services. Those who go without insurance to cover that risk—*i.e.*, who self-insure, but only for those medical expenses they will be able to afford—do not just shift *future costs* incurred when they later consume health care for which they cannot pay. They also shift *present risk* to other market participants, which is monetized in the form of higher insurance premiums now, not later, for those with insurance. The point of obtaining insurance is to internalize risk, which occurs when the insurance is obtained and the premium paid. Conversely, the failure to obtain insurance externalizes risk, and that externalization occurs at the time the insurance is not obtained. Moreover, the costs not paid by the uninsured and instead absorbed by others contribute to maintaining the ongoing viability of hospitals and other components of the Nation's health-care delivery system, which nonetheless will be available to the uninsured when they need them.

Third, even if the market for health insurance were regarded as distinct from the market for health-care services, the uninsured as a class are active in the health insurance market too. The majority of the uninsured are not permanently out of the insurance market, and the population typically moves in and out of coverage. See *Czajka*, 1, 10, 77 (more than half of uninsured spells by non-elderly adults during study period ended within six months).

iii. Finally, respondents' "inactivity" limitation "seems more redolent of Due Process Clause arguments" than any principled enumerated powers analysis.

Seven-Sky, 661 F.3d. at 19. "[I]t has no foundation in the Commerce Clause," where what "matters is whether the national problem Congress has identified is one that substantially affects interstate commerce." *Ibid.* For all of the reasons discussed above, the minimum coverage provision is an "appropriate" and "plainly adapted" means of achieving Congress's concededly legitimate ends. *McCulloch*, 17 U.S. (4 Wheat.) at 421. The Constitution entrusts the choice of that means to Congress, and there is no basis for invalidating the minimum coverage provision as beyond the commerce power, on the basis of respondents' "inactivity" argument or any other ground.

II. THE MINIMUM COVERAGE PROVISION IS INDEPENDENTLY AUTHORIZED BY CONGRESS'S TAXING POWER

A. The Minimum Coverage Provision Operates As A Tax Law

Congress's power "[t]o lay and collect Taxes, Duties, Imposts and Excises," Art. I, § 8, Cl. 1, provides an independent basis to uphold the constitutionality of the minimum coverage provision. The taxing power is "comprehensive." *Steward Mach. Co.* v. *Davis*, 301 U.S. 548, 581-582 (1937). In "passing on the constitutionality of a tax law," a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson* v. *Sears, Roebuck & Co.*, 312 U.S. 359, 363 (1941) (citation omitted). The practical operation of the minimum coverage provision is as a tax law. It is fully integrated into the tax system, will raise substantial revenue, and triggers only tax consequences for non-compliance. See *Liberty University, Inc.* v. *Geithner*, No. 10-2347, 2011

WL 3962915, at *16-*22 (4th Cir. Sept. 8, 2011) (Wynn, J., concurring), petition for cert. pending, No. 11-438 (filed Oct. 7, 2011). The Court has never held that a revenue-raising provision bearing so many indicia of taxation was beyond Congress's taxing power, and it should not do so here.

1. The minimum coverage provision amends the Internal Revenue Code to provide that a non-exempted individual who must file a federal income tax return will owe a monetary penalty, in addition to the income tax itself, for any months in which the taxpayer or dependents lack minimum coverage. 26 U.S.C.A. 5000A. The amount of the penalty will be calculated as a percentage of household income for income tax purposes, subject to a floor and a cap. 26 U.S.C.A. 5000A(c). Individuals who are not required to file income tax returns for the taxable year are not subject to the penalty. 26 U.S.C.A. 5000A(e)(2). A taxpayer's responsibility for family members depends on their status as dependents under the Internal Revenue Code, 26 U.S.C.A. 5000A(a) and (b)(3), and taxpayers filing a joint tax return are jointly liable for the penalty, 26 U.S.C.A. 5000A(b)(3)(B).

The IRS will assess and collect the penalty in the same manner as assessable penalties under the Internal Revenue Code. 26 U.S.C.A. 5000A(b)(2) and (g). Under the federal income tax system, taxpayers self-declare their income and deductions on their returns and then calculate the income tax due on their taxable income. The penalty imposed under the minimum coverage provision will be self-declared on the taxpayer's income tax return in the same way. 26 U.S.C.A. 5000A(b)(2). In addition, the Act imposes reporting requirements on health insurance providers that will assist the IRS in identifying non-compliant taxpayers. 26 U.S.C.A. 6055.

Although the Act provides that the IRS may not use criminal prosecutions, notices of federal tax liens, or levies on property to collect an unpaid penalty, 26 U.S.C.A. 5000A(g)(2), the IRS may employ offsets against federal tax refunds, 26 U.S.C. 6402(a). The IRS also may seek payment through correspondence or phone calls from IRS employees. Offsets, correspondence, and phone calls are consistently some of the most productive tools in the federal tax collection process as measured by total dollars collected. See *Payroll Tax Abuse: Hearing Before the Permanent Subcomm. on Investigations of the S. Comm. on Homeland Sec. & Gov't Affairs*, 110th Cong., 2d Sess. 137 (2008) (testimony of Linda Stiff, Deputy Comm'r, IRS). In addition, the Attorney General has general authority to file civil suits for unpaid tax liabilities. See 26 U.S.C. 6502, 7401 *et seq.*; *United States* v. *Chamberlin*, 219 U.S. 250, 261-262 (1911).

The court of appeals questioned the efficacy of those collection tools, see Pet. App. 151a-152a, but it did not take issue with the CBO's projection that the minimum coverage provision will raise billions of dollars in revenues for the general treasury each year. *Id.* at 167a; see Letter from Douglas Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, House of Representatives, Tbl. 4 (Mar. 20, 2010) (provision will raise at least $4 billion each year once the penalty is fully implemented). In short, the minimum coverage provision will plainly be "productive of some revenue" and thus satisfies a key attribute of taxation. *Sonzinsky* v. *United States*, 300 U.S. 506, 514 (1937).

2. The court of appeals perceived the goal of the minimum coverage provision as reducing the number of uninsured people, not raising revenue. Pet. App. 164a.

A tax, however, "does not cease to be valid merely because it regulates, discourages, or even definitely deters the activities taxed." *United States* v. *Sanchez*, 340 U.S. 42, 44 (1950); *Seven-Sky*, 661 F.3d at 48 n.37 (Kavanaugh, J., dissenting).

"Every tax is in some measure regulatory" in that "it interposes an economic impediment to the activity taxed as compared with others not taxed." *Sonzinsky*, 300 U.S. at 513; see *United States* v. *Kahriger*, 345 U.S. 22, 24 (1953). So long as the statute is "productive of some revenue," Congress may exercise its taxing powers irrespective of any "collateral inquiry as to the measure of the regulatory effect of a tax." *Sonzinsky*, 300 U.S. at 514. Accordingly, "[f]rom the beginning of our government, the courts have sustained taxes although imposed with the collateral intent of effecting ulterior ends which, considered apart, were beyond the constitutional power of the lawmakers to realize by legislation directly addressed to their accomplishment." *Sanchez*, 340 U.S. at 45 (citation omitted). The Court has long "abandoned the view that bright-line distinctions exist between regulatory and revenue-raising taxes." *Bob Jones University* v. *Simon*, 416 U.S. 725, 743 n.17 (1974).

Congress, in fact, has long used taxing measures to expand health insurance coverage. See pp. 4-5, *supra*. The Affordable Care Act builds on those efforts and employs familiar tools of tax incentives and tax penalties to expand the availability of insurance as a means of payment for health care services. The Act provides tax credits to eligible small businesses that provide insurance to their employees, 26 U.S.C.A. 45R, and imposes a tax liability under certain circumstances on large employers that do not offer adequate coverage to full-time employees, 26 U.S.C.A. 4980H. In parallel fashion, it

provides tax credits for many individuals who purchase health insurance through an exchange, see 26 U.S.C.A. 36B, and, as a mirror image of those credits, it imposes tax penalties on non-exempted individuals who fail to maintain minimum coverage, 26 U.S.C.A. 5000A.

Each of these measures is a proper exercise of Congress's taxing power, and each reflects Congress's broad discretion to determine how much tax is owed. In particular, just as deductions, exemptions, and credits operate to reduce an individual taxpayer's federal income tax liability based on the personal circumstances of the taxpayer, the minimum coverage penalty operates to increase the taxpayer's total tax liability based on his individual circumstances. In that sense, the minimum coverage provision is valid not only as a tax in its own right,[10] but also as an adjunct to the income tax, as it merely provides an additional input in calculating the total amount owed on the taxpayer's income tax return.

B. The Validity Of An Assessment Under The Taxing Power Does Not Depend On Whether It Is Denominated A Tax

The court of appeals concluded that the minimum coverage provision cannot be upheld under Congress's taxing power because it refers to the increased tax liability as a "penalty" rather than as a "tax." Pet. App. 157a-172a; see *Thomas More*, 651 F.3d at 551. It is well established, however, that "an exaction's label" is

[10] See, *e.g.*, 26 U.S.C. 4974 (excise tax on failure to take "minimum required distribution" from qualified retirement plan);26 U.S.C. 4980B(a) (tax imposed if, under specified circumstances, a group health plan does not "meet the requirement[]" that it offer each qualified beneficiary an opportunity to continue receiving coverage under the plan when coverage would otherwise end); 26 U.S.C. 9707 (tax penalty on mine operators for "failure" to pay required health benefit premiums for coal industry workers).

not "germane to the constitutional inquiry." *Liberty University*, 2011 WL 3962915, at *17 (Wynn, J., concurring); accord *Seven-Sky*, 661 F.3d at 48 n.37 (Kavanaugh, J., dissenting). In "passing on the constitutionality of a tax law" under the taxing power, a court is "concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it." *Nelson*, 312 U.S. at 363 (quoting *Lawrence* v. *State Tax Comm'n*, 286 U.S. 276, 280 (1932)).

Thus, in the *License Tax Cases*, 72 U.S. (5 Wall.) 462 (1867), this Court upheld under Congress's taxing power a statute that required persons pursuing intrastate gambling and liquor operations to pay for a "license" from federal tax authorities. That Congress had used the term "license" was irrelevant; the Court declared that the "granting of a license * * * must be regarded as nothing more than a mere form of imposing a tax, and of implying nothing except that the licensee shall be subject to no penalties under national law, if he pays it." *Id.* at 471. Similarly, in *New York* v. *United States*, 505 U.S. 144 (1992), the Court upheld as a "federal tax on interstate commerce" an assessment that was described in the statute as a percentage of "surcharge fees" on low-level radioactive waste. *Id.* at 171 (discussing 42 U.S.C. 2021e(d)(2)(A)).

The court of appeals nonetheless concluded that Congress had disavowed any reliance on its taxing power through its "deliberate choice of the term 'penalty.'" Pet. App. 169a. The suggestion that Congress disavowed its taxing power is insupportable. Congress placed the minimum coverage provision in the Internal Revenue Code (in Subtitle D, covering "Miscellaneous Excise Taxes"), gave the IRS enforcement power over it, and used the federal income tax return as the report-

ing mechanism. In addition, Congress's taxing power was expressly invoked to defeat constitutional points of order against the minimum coverage provision in the Senate. See 155 Cong. Rec. S13,830, S13,832 (daily ed. Dec. 23, 2009); see also 2010 House Report Pt. 1, at 265 (describing minimum coverage provision as a "tax on individuals who opt not to purchase health insurance"). And during the debates, congressional leaders defended the provision as an exercise of the taxing power. *E.g.*, 156 Cong. Rec. H1882 (daily ed. Mar. 21, 2010) (Rep. Miller); *id.* at H1826 (daily ed. Mar. 21, 2010) (Rep. Slaughter); 155 Cong. Rec. S13,751, S13,753 (daily ed. Dec. 22, 2009) (Sen. Leahy); *id.* at S13,581-13,582 (daily ed. Dec. 20, 2009) (statement of Sen. Baucus); see also Staff of Joint Comm. on Taxation, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," As Amended, in Combination with the "Patient Protection and Affordable Care Act,"* 31 (Mar. 21, 2010).

The court of appeals contrasted Congress's use of the term "penalty" in the minimum coverage provision with its use of the term "tax" in certain other provisions of the Act, *id.* at 160a-163a, and inferred that the term "penalty" was "carefully selected to denote a specific meaning," *id.* at 161a. That reasoning confused questions of statutory interpretation with the issue of congressional power. Congress's use of the term "penalty" has significance for purposes of statutory interpretation—most notably for the inapplicability of the Anti-Injunction Act, 26 U.S.C. 7421(a). But that does not justify reliance on labels to disregard the taxing power as a source of Congress's authority to enact the minimum coverage provision. To the contrary, "the constitutionality of action taken by Congress does not depend on

recitals of the power which it undertakes to exercise." *Woods* v. *Cloyd W. Miller Co.*, 333 U.S. 138, 144 (1948). Rather than strain to characterize the provision as something other than a tax law, it was the court of appeals' duty to construe the provision to uphold its constitutionality, "unless such construction is plainly contrary to the intent of Congress." *Edward J. DeBartolo Corp.* v. *Florida Gulf Coast Bldg. & Constr. Trades Council*, 485 U.S. 568, 575 (1988) ("[E]very reasonable construction must be resorted to, in order to save a statute from unconstitutionality."). Accordingly, if the minimum coverage provision can reasonably be interpreted as a tax law—as it surely can be for the reasons given above—then it must be upheld as constitutional.

C. The Placement Of The Predicate For Imposition Of The Tax Penalty In A Separate Subsection Does Not Take The Minimum Coverage Provision Outside Congress's Taxing Power

It is beyond dispute that the taxing power would permit Congress to create incentives for the purchase of health insurance by "impos[ing] a lower tax rate on people with health insurance than those without it." *Thomas More*, 651 F.3d at 550. Similarly, the taxing power "readily" permits Congress to impose a "[t]ax on individuals without acceptable health care coverage." *Seven-Sky*, 661 F.3d at 49-50 (citation omitted) (Kavanaugh, J., dissenting). In Judge Kavanaugh's view, "[t]he only reason the current statute *may not* suffice under the Taxing Clause"—a question he did not ultimately decide—"is that Section 5000A arguably does not just incentivize certain kinds of lawful behavior but also mandates such behavior." *Id.* at 48 (citing 26 U.S.C.A. 5000A(a)) (footnote omitted). To the extent that the pro-

vision means that "a citizen who does not maintain health insurance might be acting *illegally*," Judge Kavanaugh reasoned, it might be outside Congress's tax power. *Id.* at 48-49.

Even in Judge Kavanaugh's view, however, a "minor tweak to the current statutory language would definitively establish the law's constitutionality under the Taxing Clause." *Seven-Sky*, 661 F.3d at 48. He suggested, for example, that

> Congress might retain the exactions and payment amounts as they are but eliminate the legal mandate language in Section 5000A, instead providing something to the effect of: "An applicable individual without minimum essential coverage must make a payment to the IRS on his or her tax return in the amounts listed in Section 5000A(c)."

Id. at 49.

In fact, no "minor tweak to the current statutory language" (*Seven-Sky*, 661 F.3d at 48 (Kavanaugh, dissenting)) is required because Section 5000A as currently drafted is materially indistinguishable from Judge Kavanaugh's proposed revision. Statutory provisions "must be read in * * * context and with a view to their place in the overall statutory scheme." *FDA* v. *Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (quoting *Davis* v. *Michigan Dep't of the Treasury*, 489 U.S. 803, 809 (1989)). When understood as an exercise of Congress's power over taxation and read in the context of Section 5000A as a whole, subsection (a) serves only as the predicate for tax consequences imposed by the rest of the section. It serves no other purpose in the statutory scheme. Section 5000A imposes no consequence other than a tax penalty for a taxpayer's

failure to maintain minimum coverage, and it thus establishes no independently enforceable legal obligation. Indeed, Congress's understanding that subsection (a) is not separate from the tax penalties associated with it is reflected in the reference later in Section 5000A to a "penalty * * * imposed under subsection (a)." 26 U.S.C.A. 5000A(e).

Even assuming there were ambiguity on the question whether subsection (a) establishes a free-standing obligation with independent consequences, any such ambiguity must be resolved in a manner that supports the constitutionality of the legislation, for two independent reasons. First, neither the Treasury Department nor the Department of Health and Human Services interprets Section 5000A as imposing a legal obligation on applicable individuals independent of its tax-penalty consequences; each instead views it as only a predicate provision for the imposition of tax consequences. Those are the two agencies to which Congress assigned authority to administer the minimum coverage provision, see, *e.g.*, 26 U.S.C.A. 5000A(f)(1)(E) and (g)(1), and their views are thus entitled to substantial deference.

Second, to the extent the constitutionality of Section 5000A under Congress's taxing power turns on whether subsection (a) creates an independent legal obligation, the statute must be read not to do so. The decision in *New York*, *supra*, is closely on point. There, the federal statute provided that "[e]ach State *shall* be responsible for providing * * * for the disposal of . . . low-level radioactive waste," 505 U.S. at 151 (quoting 42 U.S.C. 2021c(a)(1)(A)) (emphasis added), and set forth three sets of consequences for States that failed to meet statutory deadlines, *id.* at 152-154. Notwithstanding the statute's use of the term "shall," and its imposition of

"[p]enalties for failure to comply" with specified "[r]equirements," 42 U.S.C. 2021e(e)(1) and (2), this Court "decline[d] petitioners' invitation to construe § 2021c(a)(1)(A), alone and in isolation, as a command to the States independent of the remainder of the Act." *New York*, 505 U.S. at 170. The Court observed that the statute "could plausibly be understood either as a mandate to regulate or as a series of incentives," and that, under the petitioners' view of the statute as a mandate, Section 2021c(a)(1)(A) "would clearly commandee[r] the legislative processes of the States by directly compelling them to enact and enforce a federal regulatory program." *Ibid.* (quotation marks and citation omitted). The Court rejected that interpretation and chose to interpret the statute as an integrated set of incentives, despite the fact that the challenged provision was, on its face, a stand-alone requirement in a separate statutory subsection. *Ibid.* The Court should follow the same course here in the event it concludes that the constitutionality of the minimum coverage provision under the tax power turns on whether subsection (a) creates a free-standing obligation.

CONCLUSION

The judgment of the court of appeals invalidating the minimum coverage provision should be reversed.

Respectfully submitted.

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JANUARY 2012

APPENDIX

1. Article I, Section 8 of the United States Constitution provides in relevant part:

The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States.

* * *

To regulate Commerce with foreign Nations, and among the several States, and with Indian Tribes.

* * *

To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.

2. 26 U.S.C.A. 5000A provides:

Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage.—An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment.—

(1) In general.—If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty.—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty.—

(1) In general.—The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts.—For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount.—An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income.—An amount equal to the following percentage of the excess of the taxpayer's household income for the tax-

able year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) Applicable dollar amount.—For purposes of paragraph (1)—

(A) In general.—Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

(B) Phase in.—The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) Indexing of amount.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to—

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(4) Terms relating to income and families.—For purposes of this section—

(A) Family size.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income.—The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income.—The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

[**(D)** **Repealed**. Pub. L. 111-152, Title I, § 1002(b)(1), Mar. 30, 2010, 124 Stat. 1032]

(d) **Applicable individual**.—For purposes of this section—

(1) **In general**.—The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) **Religious exemptions**.—

(A) **Religious conscience exemption**.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that such individual is—

(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

(B) Health care sharing ministry.—

(i) In general.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry.—The term "health care sharing ministry" means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and

without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals.—Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions.—No penalty shall be imposed under subsection (a) with respect to—

(1) Individuals who cannot afford coverage.—

(A) In general.—Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any por-

tion of the required contribution made through a salary reduction arrangement.

(B) Required contribution.—For purposes of this paragraph, the term "required contribution" means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by

reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to required contribution of the employee.

(D) Indexing.—In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) Members of Indian tribes.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps.—

(A) In general.—Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules.—For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships.—Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage.—For purposes of this section—

(1) In general.—The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs.—Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act,

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers); or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) **Employer-sponsored plan**.—Coverage under an eligible employer-sponsored plan.

(C) **Plans in the individual market**.—Coverage under a health plan offered in the individual market within a State.

(D) Grandfathered health plan.—Coverage under a grandfathered health plan.

(E) Other coverage.—Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan.—The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage.—The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided un-

der a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories.—Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure.—

(1) In general.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules.—Notwithstanding any other provision of law—

(A) Waiver of criminal penalties.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies.—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

3. 42 U.S.C.A. 300gg provides:

Fair health insurance premiums

(a)[1] **Prohibiting discriminatory premium rates**

(1) In general

With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

(A) such rate shall vary with respect to the particular plan or coverage involved only by—

(i) whether such plan or coverage covers an individual or family;

(ii) rating area, as established in accordance with paragraph (2);

(iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 300gg-6(c) of this title); and

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[1] So in original. No subsec. (b) enacted.

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and

(B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

(2) Rating area

(A) In general

Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

(B) Secretarial review

The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not adequate, or that a State does not establish such areas, the Secretary may establish rating areas for that State.

(3) Permissible age bands

The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(iii).

(4) Application of variations based on age or tobacco use

With respect to family coverage under a group health plan or health insurance coverage, the rating variations permitted under clauses (iii) and (iv) of

paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

(5) Special rule for large group market

If a State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange (as provided for under section 18033(f)(2)(B) of this title), the provisions of this subsection shall apply to all coverage offered in such market (other than self-insured group health plans offered in such market) in the State.

4. 42 U.S.C.A. 300gg-1 will provide:[*]

Guaranteed availability of coverage

(a) Guaranteed issuance of coverage in the individual and group market

Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.

(b) Enrollment

(1) Restriction

A health insurance issuer described in subsection (a) may restrict enrollment in coverage de-

[*] See 42 U.S.C.A. 300gg-1 note.

scribed in such subsection to open or special enrollment periods.

(2) Establishment

A health insurance issuer described in subsection (a) shall, in accordance with the regulations promulgated under paragraph (3), establish special enrollment periods for qualifying events (under section 1163 of Title 29).

(3) Regulations

The Secretary shall promulgate regulations with respect to enrollment periods under paragraphs (1) and (2).

(c) Special rules for network plans

(1) In general

In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may—

(A) limit the employers that may apply for such coverage to those with eligible individuals who live, work, or reside in the service area for such network plan; and

(B) within the service area of such plan, deny such coverage to such employers and individuals if the issuer has demonstrated, if required, to the applicable State authority that—

(i) it will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals be-

cause of its obligations to existing group contract holders and enrollees, and

(ii) it is applying this paragraph uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to such individuals employees and dependents.

(2) 180-day suspension upon denial of coverage

An issuer, upon denying health insurance coverage in any service area in accordance with paragraph (1)(B), may not offer coverage in the group or individual market within such service area for a period of 180 days after the date such coverage is denied.

(d) Application of financial capacity limits

(1) In general

A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated, if required, to the applicable State authority that—

(A) it does not have the financial reserves necessary to underwrite additional coverage; and

(B) it is applying this paragraph uniformly to all employers and individuals in the group or individual market in the State consistent with applicable State law and without regard to the claims experience of those individuals, employers and their employees (and their dependents)

or any health status-related factor relating to such individuals, employees and dependents.

(2) 180-day suspension upon denial of coverage

A health insurance issuer upon denying health insurance coverage in connection with group health plans in accordance with paragraph (1) in a State may not offer coverage in connection with group health plans in the group or individual market in the State for a period of 180 days after the date such coverage is denied or until the issuer has demonstrated to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to underwrite additional coverage, whichever is later. An applicable State authority may provide for the application of this subsection on a service-area-specific basis.

5. 42 U.S.C.A. 300gg-3 provides:

Prohibition of preexisting condition exclusions or other discrimination based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(b) Definitions

For purposes of this part—

(1) Preexisting condition exclusion

(A) In general

The term "preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(B) Treatment of genetic information

Genetic information shall not be treated as a condition described in subsection (a)(1) of this section in the absence of a diagnosis of the condition related to such information.

(2) Enrollment date

The term "enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

(3) Late enrollee

The term "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during—

(A) the first period in which the individual is eligible to enroll under the plan, or

(B) a special enrollment period under subsection (f) of this section.

(4) Waiting period

The term "waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

(c) Rules relating to crediting previous coverage

(1) "Creditable coverage" defined

For purposes of this subchapter, the term "creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage.

(C) Part A or part B of title XVIII of the Social Security Act [42 U.S.C.A. § 1395c et seq. or § 1395j et seq.].

(D) Title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.], other than coverage consisting solely of benefits under section 1928 [42 U.S.C.A. § 1396s].

(E) Chapter 55 of Title 10.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A State health benefits risk pool.

(H) A health plan offered under chapter 89 of Title 5.

(I) A public health plan (as defined in regulations).

(J) A health benefit plan under section 2504(e) of Title 22.

Such term does not include coverage consisting solely of coverage of excepted benefits (as defined in section 300gg-91(c) of this title).

(2) Not counting periods before significant breaks in coverage

(A) In general

A period of creditable coverage shall not be counted, with respect to enrollment of an individual under a group or individual health plan, if, after such period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage.

(B) Waiting period not treated as a break in coverage

For purposes of subparagraph (A) and subsection (d)(4) of this section, any period that an individual is in a waiting period for any coverage under a group or individual health plan (or for group health insurance coverage) or is in an affiliation period (as defined in subsection (g)(2) of this section) shall not be taken into account in determining the continuous period under subparagraph (A).

(C) TAA-eligible individuals

In the case of plan years beginning before February 13, 2011—

(i) TAA pre-certification period rule

In the case of a TAA-eligible individual, the period beginning on the date the individual has a TAA-related loss of coverage and ending on the date that is 7 days after the date of the issuance by the Secretary (or by any person or entity designated by the Secretary) of a qualified health insurance costs credit eligibility certificate for such individual for purposes of section 7527 of Title 26 shall not be taken into account in determining the continuous period under subparagraph (A).

(ii) Definitions

The terms "TAA-eligible individual" and "TAA-related loss of coverage" have the meanings given such terms in section 300bb-5(b)(4) of this title.

(3) Method of crediting coverage

(A) Standard method

Except as otherwise provided under subparagraph (B), for purposes of applying subsection (a)(3) of this section, a group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall count a period of creditable coverage without regard to the specific benefits covered during the period.

(B) Election of alternative method

A group health plan, or a health insurance issuer offering group or individual health insurance, may elect to apply subsection (a)(3) of this section based on coverage of benefits within each of several classes or categories of benefits specified in regulations rather than as provided under subparagraph (A). Such election shall be made on a uniform basis for all participants and beneficiaries. Under such election a group health plan or issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within such class or category.

(C) Plan notice

In the case of an election with respect to a group health plan under subparagraph (B) (whether or not health insurance coverage is provided in connection with such plan), the plan shall—

(i) prominently state in any disclosure statements concerning the plan, and state to each enrollee at the time of enrollment under the plan, that the plan has made such election, and

(ii) include in such statements a description of the effect of this election.

(D) Issuer notice

In the case of an election under subparagraph (B) with respect to health insurance coverage of-

fered by an issuer in the individual or group group[1] market, the issuer—

(i) shall prominently state in any disclosure statements concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and

(ii) shall include in such statements a description of the effect of such election.

(4) Establishment of period

Periods of creditable coverage with respect to an individual shall be established through presentation of certifications described in subsection (e) of this section or in such other manner as may be specified in regulations.

(d) Exceptions

(1) Exclusion not applicable to certain newborns

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Exclusion not applicable to certain adopted children

Subject to paragraph (4), a group health plan, and a health insurance issuer offering group or individual

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[1] So in original.

health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.

(3) Exclusion not applicable to pregnancy

A group health plan, and health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(4) Loss if break in coverage

Paragraphs (1) and (2) shall no longer apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

(e) Certifications and disclosure of coverage

(1) Requirement for certification of period of creditable coverage

(A) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, shall provide the certification described in subparagraph (B)—

(i) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision,

(ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision, and

(iii) on the request on behalf of an individual made not later than 24 months after the date of cessation of the coverage described in clause (i) or (ii), whichever is later.

The certification under clause (i) may be provided, to the extent practicable, at a time consistent with notices required under any applicable COBRA continuation provision.

(B) Certification

The certification described in this subparagraph is a written certification of—

(i) the period of creditable coverage of the individual under such plan and the coverage (if any) under such COBRA continuation provision, and

(ii) the waiting period (if any) (and affiliation period, if applicable) imposed with respect to the individual for any coverage under such plan.

(C) Issuer compliance

To the extent that medical care under a group health plan consists of group health insurance coverage, the plan is deemed to have satisfied the cer-

tification requirement under this paragraph if the health insurance issuer offering the coverage provides for such certification in accordance with this paragraph.

(2) Disclosure of information on previous benefits

In the case of an election described in subsection (c)(3)(B) of this section by a group health plan or health insurance issuer, if the plan or issuer enrolls an individual for coverage under the plan and the individual provides a certification of coverage of the individual under paragraph (1)—

(A) upon request of such plan or issuer, the entity which issued the certification provided by the individual shall promptly disclose to such requesting plan or issuer information on coverage of classes and categories of health benefits available under such entity's plan or coverage, and

(B) such entity may charge the requesting plan or issuer for the reasonable cost of disclosing such information.

(3) Regulations

The Secretary shall establish rules to prevent an entity's failure to provide information under paragraph (1) or (2) with respect to previous coverage of an individual from adversely affecting any subsequent coverage of the individual under another group health plan or health insurance coverage.

(f) Special enrollment periods

(1) Individuals losing other coverage

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if each of the following conditions is met:

(A) The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent.

(B) The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or issuer (if applicable) required such a statement at such time and provided the employee with notice of such requirement (and the consequences of such requirement) at such time.

(C) The employee's or dependent's coverage described in subparagraph (A)—

(i) was under a COBRA continuation provision and the coverage under such provision was exhausted; or

(ii) was not under such a provision and either the coverage was terminated as a result of loss

of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated.

(D) Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (C)(i) or termination of coverage or employer contribution described in subparagraph (C)(ii).

(2) For dependent beneficiaries

(A) In general

If—

(i) a group health plan makes coverage available with respect to a dependent of an individual,

(ii) the individual is a participant under the plan (or has met any waiting period applicable to becoming a participant under the plan and is eligible to be enrolled under the plan but for a failure to enroll during a previous enrollment period), and

(iii) a person becomes such a dependent of the individual through marriage, birth, or adoption or placement for adoption,

the group health plan shall provide for a dependent special enrollment period described in subparagraph (B) during which the person (or, if not other-

wise enrolled, the individual) may be enrolled under the plan as a dependent of the individual, and in the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage.

(B) Dependent special enrollment period

A dependent special enrollment period under this subparagraph shall be a period of not less than 30 days and shall begin on the later of—

(i) the date dependent coverage is made available, or

(ii) the date of the marriage, birth, or adoption or placement for adoption (as the case may be) described in subparagraph (A)(iii).

(C) No waiting period

If an individual seeks to enroll a dependent during the first 30 days of such a dependent special enrollment period, the coverage of the dependent shall become effective—

(i) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

(ii) in the case of a dependent's birth, as of the date of such birth; or

(iii) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(3) Special rules for application in case of Medicaid and CHIP

(A) In general

A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if either of the following conditions is met:

(i) Termination of Medicaid or CHIP coverage

The employee or dependent is covered under a Medicaid plan under title XIX of the Social Security Act [42 U.S.C.A. 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C.A. 1397aa et seq.] and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage.

(ii) Eligibility for employment assistance under Medicaid or CHIP

The employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under such Medicaid plan or State child health plan (including under any waiver or dem-

onstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

(B) Coordination with Medicaid and CHIP

(i) Outreach to employees regarding availability of Medicaid and CHIP coverage

(I) In general

Each employer that maintains a group health plan in a State that provides medical assistance under a State Medicaid plan under title XIX of the Social Security Act [42 U.S.C.A 1396 et seq.], or child health assistance under a State child health plan under title XXI of such Act [42 U.S.C.A 1397aa et seq.], in the form of premium assistance for the purchase of coverage under a group health plan, shall provide to each employee a written notice informing the employee of potential opportunities then currently available in the State in which the employee resides for premium assistance under such plans for health coverage of the employee or the employee's dependents. For purposes of compliance with this subclause, the employer may use any State-specific model notice developed in accordance with section 1181(f)(3)(B)(i)(II) of Title 29.

(II) Option to provide concurrent with provision of plan materials to employee

An employer may provide the model notice applicable to the State in which an employee resides concurrent with the furnishing of materials notifying the employee of health plan eligibility, concurrent with materials provided to the employee in connection with an open season or election process conducted under the plan, or concurrent with the furnishing of the summary plan description as provided in section 1024(b) of Title 29.

(ii) Disclosure about group health plan benefits to States for Medicaid and CHIP eligible individuals

In the case of an enrollee in a group health plan who is covered under a Medicaid plan of a State under title XIX of the Social Security Act [42 U.S.C.A 1396 et seq.] or under a State child health plan under title XXI of such Act [42 U.S.C.A 1397aa et seq.], the plan administrator of the group health plan shall disclose to the State, upon request, information about the benefits available under the group health plan in sufficient specificity, as determined under regulations of the Secretary of Health and Human Services in consultation with the Secretary that require use of the model coverage coordination disclosure form developed under section 311(b)(1)(C) of the Children's Health Insurance Reauthorization Act of 2009, so as to permit the State to make a determination (under paragraph (2)(B), (3), or (10) of section 2105(c) of the Social Security Act [42 U.S.C.A 1397ee(c)(2)(B),

(3), (10)] or otherwise) concerning the cost-effectiveness of the State providing medical or child health assistance through premium assistance for the purchase of coverage under such group health plan and in order for the State to provide supplemental benefits required under paragraph (10)(E) of such section or other authority.

(g) Use of affiliation period by HMOs as alternative to preexisting condition exclusion

(1) In general

A health maintenance organization which offers health insurance coverage in connection with a group health plan and which does not impose any preexisting condition exclusion allowed under subsection (a) of this section with respect to any particular coverage option may impose an affiliation period for such coverage option, but only if—

(A) such period is applied uniformly without regard to any health status-related factors; and

(B) such period does not exceed 2 months (or 3 months in the case of a late enrollee).

(2) Affiliation period

(A) "Affiliation period" defined

For purposes of this subchapter, the term "affiliation period" means a period which, under the terms of the health insurance coverage offered by the health maintenance organization, must expire before the health insurance coverage becomes effective. The organization is not required to provide health care services or benefits during such period

and no premium shall be charged to the participant or beneficiary for any coverage during the period.

(B) Beginning

Such period shall begin on the enrollment date.

(C) Runs concurrently with waiting periods

An affiliation period under a plan shall run concurrently with any waiting period under the plan.

(3) Alternative methods

A health maintenance organization described in paragraph (1) may use alternative methods, from those described in such paragraph, to address adverse selection as approved by the State insurance commissioner or official or officials designated by the State to enforce the requirements of this part for the State involved with respect to such issuer.

6. 42 U.S.C.A. 300gg-4 provides in pertinent part:

Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In general

A group health plan and a health insurance issuer offering group or individual health insurance coverage may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan or coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(1) Health status.

(2) Medical condition (including both physical and mental illnesses).

(3) Claims experience.

(4) Receipt of health care.

(5) Medical history.

(6) Genetic information.

(7) Evidence of insurability (including conditions arising out of acts of domestic violence).

(8) Disability.

(9) Any other health status-related factor determined appropriate by the Secretary.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering group or individual health insurance coverage, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer or individual may be charged for coverage under a group health plan except as provided in paragraph (3) or individual health coverage, as the case may be; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information

(A) In general

For purposes of this section, a group health plan, and health insurance issuer offering group health insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering group or individual health insurance coverage to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic informa-

tion about other group members and to further increase the premium for the employer.

* * * * *

7. 42 U.S.C.A. 18091 provides:

Requirement to maintain minimum essential coverage

(a) Findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this subsection referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the re-

quirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 *et seq.*), the Public Health Service Act (42 U.S.C. 201 *et seq.*), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many

individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In *United States v. South-Eastern Underwriters Association* (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

8. 29 U.S.C. 1182 (2006 & Supp. III 2009) provides in pertinent part:

Prohibiting discrimination against individual participants and beneficiaries based on health status

(a) In eligibility to enroll

(1) In general

Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

(2) No application to benefits or exclusions

To the extent consistent with section 1181 of this title, paragraph (1) shall not be construed—

(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) Construction

For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer may be charged for coverage under a group health plan except as provided in paragraph (3); or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

(3) No group-based discrimination on basis of genetic information

(A) In general

For purposes of this section, a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not adjust premium or contribution amounts for the group covered under such plan on the basis of genetic information.

(B) Rule of construction

Nothing in subparagraph (A) or in paragraphs (1) and (2) of subsection (d) shall be construed to limit the ability of a health insurance issuer offering health insurance coverage in connection with a group health plan to increase the premium for an employer based on the manifestation of a disease or disorder of an individual who is enrolled in the plan. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the employer.

* * * * *

9. 42 U.S.C. 300gg-1 (2006) provides:

Prohibiting discrimination against individual participants and beneficiaries based on health status (a)

(a) In eligibility to enroll

(1) In general

Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(A) Health status.

(B) Medical condition (including both physical and mental illnesses).

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

(G) Evidence of insurability (including conditions arising out of acts of domestic violence).

(H) Disability.

(2) No application to benefits or exclusions

To the extent consistent with section 300gg of this title, paragraph (1) shall not be construed—

(A) to require a group health plan, or group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage, or

(B) to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) Construction

For purposes of paragraph (1), rules for eligibility to enroll under a plan include rules defining any applicable waiting periods for such enrollment.

(b) In premium contributions

(1) In general

A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction

Nothing in paragraph (1) shall be construed—

(A) to restrict the amount that an employer may be charged for coverage under a group health plan; or

(B) to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

10. 42 U.S.C. 300gg-11(a) (2006) provides:

Guaranteed availability of coverage for employers in group market

(a) Issuance of coverage in small group market

(1) In general

Subject to subsections (c) through (f) of this section, each health insurance issuer that offers health insurance coverage in the small group market in a State—

(A) must accept every small employer (as defined in section 300gg-91(e)(4) of this title) in the State that applies for such coverage; and

(B) must accept for enrollment under such coverage every eligible individual (as defined in paragraph (2)) who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan and may not place any restriction which is inconsis-

tent with section 300gg-1 of this title on an eligible individual being a participant or beneficiary.

(2) "Eligible individual" defined

For purposes of this section, the term "eligible individual" means, with respect to a health insurance issuer that offers health insurance coverage to a small employer in connection with a group health plan in the small group market, such an individual in relation to the employer as shall be determined—

(A) in accordance with the terms of such plan,

(B) as provided by the issuer under rules of the issuer which are uniformly applicable in a State to small employers in the small group market, and

(C) in accordance with all applicable State laws governing such issuer and such market.